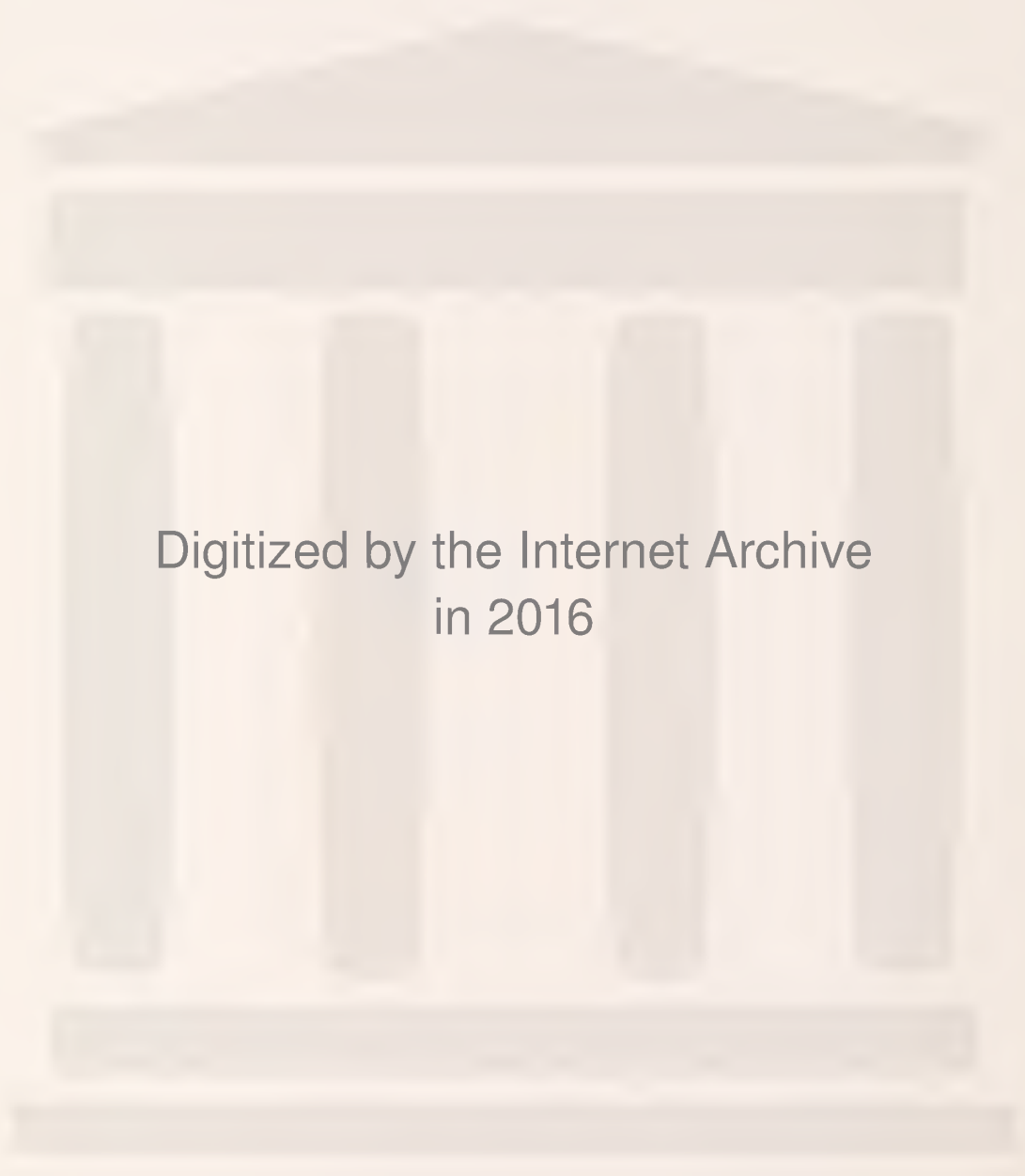


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JOURNAL of the **MISSISSIPPI** State Medical Association



Dr. B. F. Ward, MSMA President, 1881

Yin

DRAMATIC NEW CLINICAL PROOF*

In the treatment of impetigo—

- **100% cure rate with Tegopen®** (cloxacillin sodium)
- **only a 60% cure rate with penicillin V-K**



As seen on admission



After one week of penicillin V-K therapy



Two weeks after initiation of TEGOPEN therapy

Treatment failure was judged to have occurred when lesions increased in size and/or number during the initial week of treatment with penicillin V-K. No treatment failures occurred with Tegopen.

*Data on file, Bristol Laboratories.

Brief Summary of Prescribing Information

TEGOPEN®
(cloxacillin sodium)
Capsules and Oral Solution

For complete information, consult Official Package Circular.

(12) 9/11/75

INDICATIONS:

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

RESULTS OF ORAL THERAPY revealed a high percentage of treatment failures with penicillin V potassium, but *no* failures with Tegopen.

		Given Tegopen® (cloxacillin sodium)	Given penicillin V-K
<i>Staphylococcus aureus</i>	(78 patients)	39	39
Returned to clinic at one week	.....	29†	38†
Treatment failure at one week	.....	0	18 (47.4%)
<i>Staphylococcus aureus</i> and <i>Streptococcus pyogenes</i>	(9 patients)	4	5
Returned to clinic at one week	.....	4	5
Treatment failure at one week	.....	0	2 (40%)
No initial bacterial growth	(14 patients)	9	5
All 14 healed, regardless of which antibiotic was administered.			
Beta-hemolytic <i>Streptococcus</i>	(1 patient)	0	1
TOTALS:	102 patients	52 patients	50 patients

†Eleven patients did not return for their one-week checkup. These were all called by telephone, and their families reported

the lesions had healed. One patient was dropped from the study, early, because of adverse reaction to medication.

STUDY: DESCRIPTION/PROTOCOL

- 102 nonselected subjects, with initial bacteriology as follows: 77% *Staphylococcus aureus*, 9% mixed *Staphylococcus aureus* and *Streptococcus pyogenes*, and 1% beta-hemolytic *Streptococcus*.†
- All patients were given randomized therapy—Tegopen capsules or oral solution, or penicillin V-K tablets or oral solution, in recommended dosages according to body weight.

- All patients were evaluated after one week's therapy. If there was no improvement, therapy was switched to the other antibiotic. The "other antibiotic" proved to be Tegopen 100% of the time because no treatment failures had occurred with Tegopen.
- A final assessment of progress was made two weeks after initiation of Tegopen therapy.

†The remainder, to equal 100%, consisted of 14 patients (13%) who exhibited no initial bacterial growth. These 14 were all healed, whether given Tegopen or penicillin V-K.

TEGOPEN®

(cloxacillin sodium)

**—effective therapy for staph infections
of the skin and skin structures**

WARNING:

Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

PRECAUTIONS:

The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:

Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose

stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:

Adults: 250 mg q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

SUPPLIED:

Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100
Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

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ON THE COVER

Dr. Benjamin F. Ward of Winona was president of the Mississippi State Medical Association in 1881-82. He was born in Abbeville County, SC, February 25, 1836. He was the youngest child of William F. and Martha (Mecklin) Ward, both of Irish lineage.

Following the death of his father, Dr. Ward's family moved to Mississippi, settling in Choctaw County in 1846. As a young man Dr. Ward moved to Carroll County where he taught school and read medicine.

He took his first course of medical lectures at the University of Louisiana and graduated from the Atlanta Medical College in 1859, returning to Carroll County where he engaged in practice until 1861. At that time he enlisted as a private in the Eleventh Mississippi infantry. After one year of service he was appointed field surgeon of this regiment, and later served as brigade surgeon for Gen. Joseph R. Davis. He was then appointed to the army medical board, with the division of Maj. Gen. Heth, and served in this capacity until the end of the war. He then settled in Winona.

Dr. Ward was well known throughout the state as a speaker and writer, "not alone on subjects pertaining to his profession, and in both capacities his services were often requisitioned." He served as president of the State Board of Health during the administration of Governor Vardaman and was for many years chief surgeon of the Mississippi Division of the United Confederate Veterans.

Dr. Ward was present at the 1869 meeting of the association and was one of the delegates chosen to represent the new association in the AMA. He served as member of the Judicial Council in 1885-86 and again from 1887-1889. He delivered the Oration at the meeting in 1881 and was a member of the executive committee from 1889 to 1893. — from *Rowland's History of Mississippi and Transactions of the Mississippi State Medical Association*.

JOURNAL MSMA encourages your participation. Comments, inquiries and suggestions are invited.

JOURNAL of the **MISSISSIPPI** State Medical Association



January 1982, Volume XXIII, Number 1

125th Anniversary Year

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Ru-Tuss Tablets act continuously for 10 to 12 hours.
Ru-Tuss Tablets are an oral antihistaminic, nasal decongestant and anti-secretory preparation.

INDICATIONS AND USAGE Ru-Tuss Tablets provide relief of the symptoms resulting from irritation of sinus, nasal and upper respiratory tract tissues. Phenylephrine and phenylpropanolamine combine to exert a vasoconstrictive and decongestive action while chlorpheniramine maleate decreases the symptoms of watering eyes, post nasal drip and sneezing which may be associated with an allergic-like response. The belladonna alkaloids, hyoscyamine, atropine and scopolamine further augment the anti-secretory activity of Ru-Tuss Tablets.

CONTRAINDICATIONS Hypersensitivity to antihistamines or sympathomimetics. Ru-Tuss Tablets are contraindicated in children under 12 years of age and in patients with glaucoma, bronchial asthma and women who are pregnant. Concomitant use of MAO inhibitors is contraindicated.

WARNINGS Ru-Tuss Tablets may cause drowsiness. Patients should be warned of the possible additive effects caused by taking antihistamines with alcohol, hypnotics, sedatives or tranquilizers.

PRECAUTIONS Ru-Tuss Tablets contain belladonna alkaloids, and must be administered with care to those patients with glaucoma, or urinary bladder neck obstruction. Caution should be exercised when Ru-Tuss Tablets are given to patients with hypertension, cardiac or peripheral vascular disease or hyperthyroidism. Patients should avoid driving a motor vehicle or operating dangerous machinery (See Warnings).

OVERDOSAGE Since the action of sustained release products may continue for as long as 12 hours, treatment of overdoses directed at reversing the effects of the drug and supporting the patient should be maintained for at least that length of time. Saline cathartics are useful for hastening evacuation of unreleased medication. In children and infants, antihistamine overdosage may produce convulsions and death.

ADVERSE REACTIONS Hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia may occur. Other adverse reactions to Ru-Tuss Tablets may be drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, and insomnia. Large overdoses may cause tachypnea, delirium, fever, stupor, coma and respiratory failure.

DOSAGE AND ADMINISTRATION Adults and children over 12 years of age, one tablet morning and evening. Not recommended for children under 12 years of age. Tablets are to be swallowed whole.

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RU-TUSS[®] Expectorant

DESCRIPTION

Each fluid ounce of Ru-Tuss Expectorant contains	
Codeine Phosphate	65.8 mg
(WARNING: MAY BE HABIT FORMING)	
Phenylephrine Hydrochloride	30 mg
Phenylpropanolamine Hydrochloride	20 mg
Pheniramine Maleate	20 mg
Pyrilamine Maleate	20 mg
Ammonium Chloride	200 mg
Alcohol	5%

Ru-Tuss Expectorant is an oral antitussive, antihistaminic, nasal decongestant and expectorant preparation.

INDICATIONS AND USAGE Ru-Tuss Expectorant is indicated for symptomatic relief of upper respiratory congestion associated with pharyngitis, tracheitis, bronchitis, and allergic rhinitis. Also, for the temporary relief of symptoms associated with hay fever allergies, nasal congestion and cough due to the common cold.

CONTRAINDICATIONS Hypersensitivity to antihistamines. Concomitant use of an antihypertensive or antidepressant drug containing a monoamine oxidase inhibitor is contraindicated.

Ru-Tuss Expectorant is contraindicated in patients with glaucoma, bronchial asthma and in women who are pregnant.

WARNINGS Ru-Tuss Expectorant contains codeine phosphate, therefore, the patient should be warned of the potential that this drug may be habit forming. Ru-Tuss Expectorant may cause drowsiness. Patients should be warned of the possible additive effect caused by taking antihistamines with alcohol, hypnotics, sedatives and tranquilizers.

PRECAUTIONS Patients taking Ru-Tuss Expectorant should avoid driving a motor vehicle or operating dangerous machinery (See Warnings). Caution should be taken with patients having hypertension, diabetes, hyperthyroidism and cardiovascular disease.

Caution should also be used in patients with pulmonary, hepatic or renal insufficiency.

ADVERSE REACTIONS Ru-Tuss Expectorant may cause drowsiness, lassitude, giddiness, dryness of mucous membranes, tightness of the chest, thickening of bronchial secretion, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, and insomnia. Overdoses may cause restlessness, excitation, delirium, tremors, euphoria, metabolic acidosis, stupor, tachycardia and even convulsions.

DOSAGE AND ADMINISTRATION Adults: 1 or 2 teaspoonsful, orally, every 4 hours, not to exceed 10 teaspoonsful in any 24-hour period.

Children 6 to 12 years of age: $\frac{1}{2}$ the adult dose, not to exceed 6 teaspoonsful in any 24-hour period. Children 2 to 6 years of age: $\frac{1}{2}$ teaspoonful every 4 hours, not to exceed 3 teaspoonsful in any 24-hour period. Children under 2 years of age: Use only as directed by a physician.

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114th Annual Session

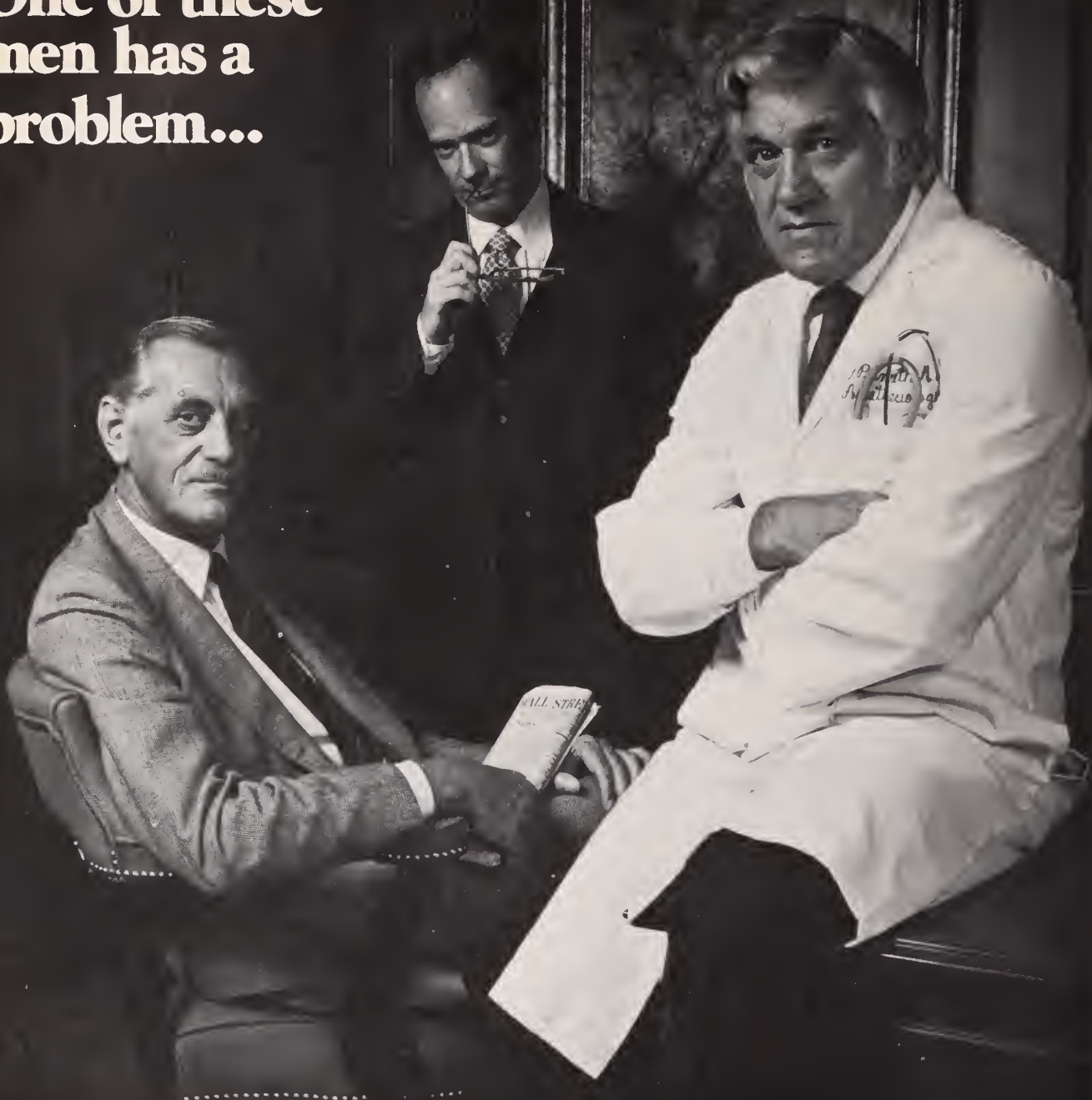
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NEWSLETTER

January 1982

Dear Doctor:

Physicians can expect a substantial increase in requests for medical reports, according to an alert issued by the Social Security Administration. The agency is beginning a review of the four million people receiving disability benefits, as mandated by a 1980 law requiring a review of nearly every disability case at least once every three years. As many as 150,000 people may be dropped from the program this fiscal year.

Social Security urged physicians to point out to their patients that they, the physicians, do not give an opinion or participate in the decision on whether the patients are disabled. These decisions are made by individual state disability offices.

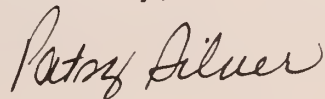
The New Jersey Legislature recently enacted three pieces of legislation on smoking: a bill to prohibit smoking in elevators in every building other than single family dwellings; a bill to control smoking in health care facilities and waiting rooms of health care professionals' offices; and a bill to restrict smoking to designated areas of schools, colleges and universities.

The Arkansas Supreme Court ruled that the state's Freedom of Information act requires meetings of a hospital's credentials committee be open to the public. A local reporter sued after being denied admittance to such a meeting. Testimony and vote on the matter of staff privileges must be in public session, the court said, but discussion by committee members may be in executive session.

Latest public and physician opinion polls sponsored by the AMA reveal that cost is the main problem facing health care today. The public remains satisfied with the quality of care, but is concerned about ability to pay for extended illnesses. Public confidence in the AMA continues. Physicians cite the cost of health care, government controls, and problems of delivery and access.

The Mississippi State Board of Health has announced a publicity campaign to "Make Measles a Memory in Mississippi." Beginning this month, public service announcements will urge persons under 21 to verify their measles immunization. The messages will remind those in doubt to contact their doctor or local health department about receiving measles immunization.

Sincerely,



Patsy Silver
Managing Editor

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Cyclapen®-W is just as effective in otitis media and streptococcal tonsillopharyngitis†.²

Cyclapen®-W produces a significantly lower incidence of the most common side effect, diarrhea.²

CYCLAPEN®-W
(cyclacillin) Tablets/Suspension

Rapid onset of action with fewer side effects.

*Rapidly excreted unchanged in urine. Clinical efficacy may not always correlate with blood levels.

†Due to susceptible organisms.

1. Ginsburg CM, McCracken GH Jr, Zweighaft TC, Clahsen JC: Comparative pharmacokinetics of cyclacillin and amoxicillin in infants and children. *Antimicrob Ag Chemother* 19:1086-1088 (June) 1981.

2. Multicenter trials. Data to be published.

See important information on page after next.

Compared to ampicillin

Faster peak. Fewer problems.

... in adults and children

Cyclapen®-W (cyclacillin) produces peak serum concentrations* almost four times higher and over one hour earlier.³

Cyclapen®-W is just as effective in otitis media, bronchitis, pneumonia, urinary tract infections and infections of skin and skin structures†.³

Cyclapen®-W produces a significantly lower incidence of diarrhea and skin rash.³

CYCLAPEN®-W
(cyclacillin) Tablets/Suspension

Rapid onset of action with fewer side effects.

*Rapidly excreted unchanged in urine. Clinical efficacy may not always correlate with blood levels.

†Due to susceptible organisms.

3. Data on file. Wyeth Laboratories.
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See important information on adjoining page.

Wyeth Laboratories
Philadelphia, Pa. 19101

Cyclapen® -W (cyclacillin)

Indications

Cyclacillin has less *in vitro* activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure. Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day‡
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day‡
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.

†depending on severity

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DATELINE

Hospital Room Jackson, MS - The average cost for a semi-private
Costs Less room in a Mississippi hospital is \$88.50 a day
 compared with the national average of \$151 a day,
according to a recent survey by the Equitable Life Assurance Society. Inten-
sive care units in Mississippi average \$236 a day, while the national average
is \$356. The highest average room rate across the nation was in California,
with \$245 for a private room and \$212 for a semi-private room.

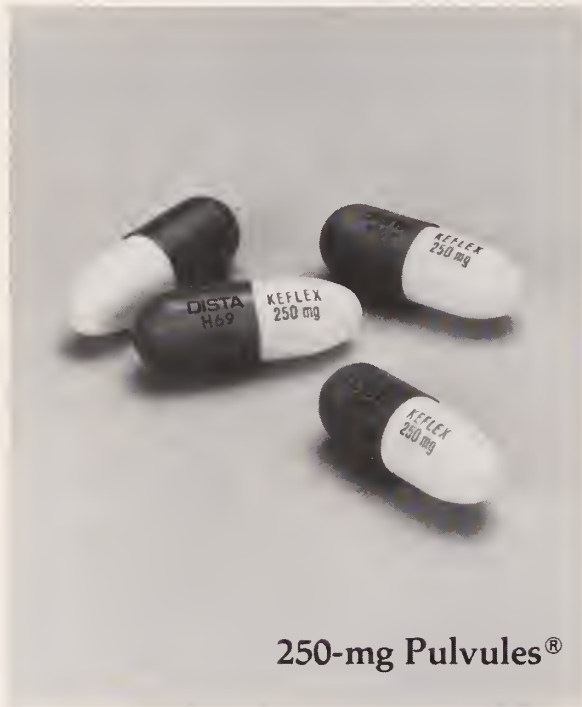
Warning About Jackson, MS - MSMA members are cautioned about an
Charity's Claims organization called United Charities Foundation, which
 claims that the American Medical Association will
benefit from the sale of chances on a New York country estate, a car, and some
cash. Some members report having been contacted by the organization. The AMA's
general counsel reports that there is no connection between the AMA and this
group, which may be a total sham.

Society Issues Jackson, MS - Central Medical Society has issued to
Vehicle Caution local newspaper editors a statement of concern regard-
 ing the dangers of small recreational vehicles such
as three-wheeled motorcycles (ATCs), go-carts, and trail bikes. The physicians
of the society's seven-county area are treating increasing numbers of injuries
related to these popular vehicles. The society urges public awareness of the
dangers, enforcement of laws, and safety education programs.

Competition Options Washington, DC - The Cabinet Council on Human Relations
Under Study is reportedly considering options developed by the
 Competition Task Force. Options include: tax deduction
limits on contributions to employee health plans; tax credit to employers offer-
ing a choice of health plans; increased excise taxes on alcohol and cigarettes;
Medicare changes with coinsurance and \$2,500 limit on out-of-pocket costs;
Medicare voucher plan with some private plan premium reimbursement.

Report Says Chicago, IL - Nearly half the patients admitted to
ICU's Overutilized George Washington University Medical Center's intensive
 care unit did not need intensive treatment, says a
report in the December 11 issue of JAMA. The study by Dr. William A. Knaus
covered a period of eight months, during which he found that the patients
mainly needed close nursing attention, which could have been accomplished
elsewhere in the hospital rather than ICU.

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INDICATIONS: *Therapeutically* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically*, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neo-



mycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching, it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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Motrin[®] vs aspirin w/codeine...

(ibuprofen)

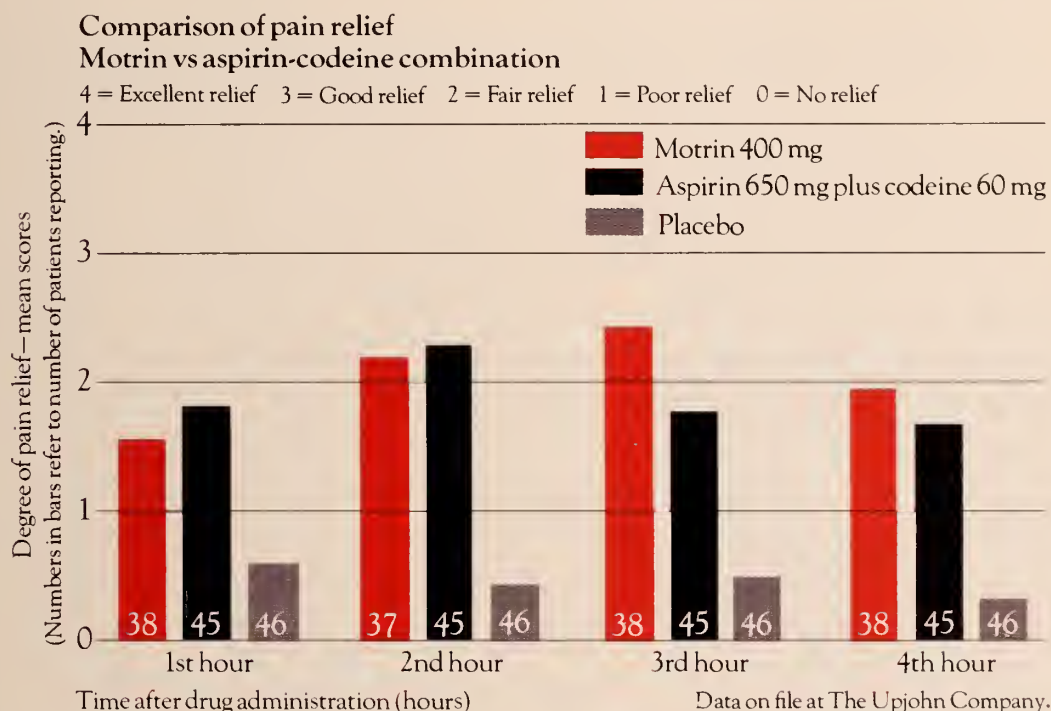


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Indications and Usage: Relief of mild to moderate pain

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin*: Used concomitantly may decrease Motrin blood levels. *Coumarin*: Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,^{*} epigastric pain,^{*} heartburn,^{*} diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness, headache, nervousness. **Dermatologic:** Rash^{*} (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

^{*}Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease. Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain. Do not exceed 2400 mg per day.

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ORIGINAL PAPERS

Catamenial Pneumothorax

W. WILSON DEFORE, JR., M.D. and GEORGE GILLESPIE, M.D.

Jackson, Mississippi

SPONTANEOUS PNEUMOTHORAX frequently is seen in the young and healthy male patient. The incidence of spontaneous pneumothorax in females is rare and accounts for less than 10% of the total clinical problem. An unusual presentation of recurrent spontaneous pneumothorax in association with menstruation is seen in females and has been called catamenial pneumothorax. Slightly more than 30 patients have been described in the world literature. A case report is presented and the clinical features of this syndrome are reviewed.

Case Report

S. P., a 48-year-old female presented with a six day history of increasing sharp, right-sided chest pain, a non-productive cough, and dyspnea. Physical examination revealed decreased breath sounds over the right hemithorax. Chest x-ray at the time of hospital admission revealed a pneumothorax confined to the lower portion of the right pleural space. The patient's general physical condition was otherwise good and laboratory work was essentially within normal limits. The patient was treated with a tube thoracostomy with drainage and slowly sealed the air leak over a period of days with complete re-expansion of the right lung.

Past medical history was significant in that the patient related multiple episodes of pneumothorax in the past, all related to her menstrual periods. The initial onset was at age 36, and since that time she had experienced an estimated 15 to 20 episodes, always occurring on the right side, usually with pain and minimal collapse of the right lung. She had

required tube thoracostomy drainage three times previously, and at age 40 had undergone a right thoracotomy with pleurectomy. Following surgery she had occasional similar episodes, but none requiring chest tube drainage. In total, an estimated 15 to 20 episodes were recalled by the patient.

Because of the similarity of these episodes of right-sided chest pain, collapse of the lung, and relation to her menstrual periods, it was felt that the patient had the syndrome of catamenial pneumothorax. At age 48 she underwent a total abdominal hysterectomy with a bilateral salpingo-oophorectomy. The pathology report showed chronic cervicitis, leiomyomata uteri, and a secretory endometrium. Following recovery from this procedure the patient has done well and has not experienced further episodes of pneumothorax over a three-year period of follow-up.

Discussion

Spontaneous pneumothorax is a common thoracic surgical problem. Approximately 90% of these episodes occur in young, healthy male patients, and most often the etiology is due to pulmonary blebs. However, an unusual syndrome of recurrent spontaneous pneumothorax concurrent with menstruation in females has been called catamenial pneumothorax. Less than 30 cases have been reported in the world literature, and the typical patient is a 30- to 40-year-old female patient with a history of recurrent right-sided chest pain, dyspnea, and chest x-ray verification of a right-sided pneumothorax.

The first report of catamenial pneumothorax was by Maurer¹ in 1958. In this report he described a female with 15 episodes of recurrent right pneumothorax associated with menstruation. At

Dr. Defore and Dr. Gillespie are in the private practice of surgery in Jackson, MS.

thoracotomy, endometrial implants were excised from the diaphragm, and a subsequent laparotomy also revealed pelvic endometriosis to be present. Wingfield² and Mayo³ subsequently reported two females with repeated episodes of right pneumothorax with menstruation. However, in these patients no lesions of endometriosis were found. Kovarik⁴ reported a female with a similar syndrome and lesions were excised from the diaphragm and also the apex of the lung, both revealing the presence of endometriosis. The pathogenesis and etiology of this syndrome still remain a source of conjecture. Maurer¹ has suggested that air passes through the genital tract into the peritoneal cavity and then into the pleural space by way of diaphragmatic perforations. The presence of congenital openings in the diaphragm have been suggested by several authors as the cause of the appearance of air in the pleural space.⁵ The increased incidence of endometriosis associated with diaphragmatic defects lends credence to the role of endometrial implants on both the diaphragmatic and pleural surfaces with subsequent sloughing and resultant air leaks. Of the reports in the literature to date, approximately 25% to 30% have associated pleural or diaphragmatic endometriosis demonstrated, or the presence of diaphragmatic defects. The diagnosis is easily made in the female with clinical features of this syndrome and chest x-ray evidence of a right-sided pneumothorax. Furman⁶ has recommended the utilization of fiberoptic pleuroscopy to evaluate the lung and diaphragmatic surfaces as well as ascertain the presence of endometrial implants before definitive treatment is carried out. In his patients, Furman has actually revealed the presence of diaphragmatic perforations in a patient with pelvic endometriosis and catamenial pneumothorax.

Treatment usually involves a tube thoracostomy drainage until all air leaks have stopped, and there is x-ray confirmation of full expansion of the involved lung. In the patient with recurrent episodes, usually a thoracotomy with pleurodesis or pleurectomy and evaluation of the diaphragmatic pleural surfaces for endometrial implants is required. There is support for closed tube pleurodesis utilizing chemical sclerosing agents as previously reported in patients with recurrent malignant pleural effusion. However, the

role of gynecological surgical ablation and the utilization of ovulatory suppressing agents still remain controversial in this syndrome.⁷

Thus there appears to be a catamenial relationship to these episodes, with a failure to occur at other times, including during pregnancy or during the utilization of ovulatory suppressing agents.

Summary

The diagnosis of catamenial pneumothorax should be suspected in a female patient presenting with episodes of recurrent right-sided chest pain, dyspnea, and pneumothorax on chest x-ray. There is usually a temporal relationship of the menstrual period to the onset of the chest pain and resultant pneumothorax. The pathogenesis of this syndrome remains unclear, but pleural and diaphragmatic endometrial implants have been demonstrated in several cases. The presence of pelvic endometriosis in this problem is probably more frequent than suspected. The etiology most likely is related to air leaks from subpleural endometrial implants and diaphragmatic perforations of endometrial or congenital origin with a resultant pleural-peritoneal communication. Treatment includes a closed tube thoracotomy initially, or with recurrent episodes, ovulatory suppressing agents or a thoracotomy is usually suggested along with surgical treatment of the pelvic endometriosis.

★★★

P.O. Box 4180 (39216)

References

1. Maurer, E. R., et al: Chronic recurring spontaneous pneumothorax due to endometriosis of the diaphragm. *J.A.M.A.* 168:2013, 1958.
2. Wingfield, R. D.: Chronic recurring spontaneous pneumothorax associated with menstruation. *Md. S. Med. J.* 10:344, 1961.
3. Mayo, P.: Recurrent spontaneous pneumothorax concomitant with menstruation. *J. Thor. and Cardiovas. Surg.* 46:415, 1963.
4. Kovarik, J. L. and Tell, G. D.: Thoracic endometriosis with recurrent spontaneous pneumothorax. *J.A.M.A.* 196:595, 1966.
5. Crutcher, R. R., et al: Recurring spontaneous pneumothorax associated with menstruation. *J. Thor. and Cardiovas. Surg.* 54:599, 1957.
6. Furman, W. R., et al: Catamenial pneumothorax evaluated by fiberoptic pleuroscopy. *Am. Rev. Resp. Dis.* 121:137, 1980.
7. Dnowski, W. P.: Antagonadotropins (Danazol) in the treatment of endometriosis. *Am. J. Obst. and Gynec.* 130:41, 1978.

Seminar in Perinatology: Respiratory Distress Due to Listeriosis

JOHN E. RAWSON, M.D., CHARLES A. FRIEDMAN, M.D. and
BERNARD I. BLUMENTHAL, M.D.

Jackson, Mississippi

THE CLINICAL SYNDROMES of early-onset Group B streptococcal (GBS) sepsis and early-onset listeriosis are clinically indistinguishable, with respiratory distress starting shortly after birth. In this seminar such a case is presented.

DR. RAWSON: A 2.5kg term female infant was transferred to this hospital for respiratory distress beginning at birth. The infant was the full-term product of a 31-year-old gravida 2, para 1, black female whose pregnancy had been complicated by an episode of fever, chills and abdominal pain two weeks prior to delivery. There was no prenatal care. The mother lived in a remote rural farm area in extremely poor sanitary conditions. She was found in early labor by a neighbor, having fallen by the side of a country road, and was brought to a nearby hospital for delivery. The infant was born by spontaneous vertex delivery with rupture of the membranes at delivery. The Apgar score was 3 at one minute and 4 at five minutes. Intrauterine passage of meconium was noted. The baby's airway was suctioned, and 35% oxygen was administered by face mask. After a blood culture was obtained, the infant was given 100mg of ampicillin and 20mg kanamycin IM. The baby was transferred to Hinds General Hospital by the Newborn Transport Team.

Examination at Hinds General Hospital intensive care nursery at eight hours of age, showed the patient to be a term female infant in moderate respiratory distress breathing 35% oxygen. Temperature was 99.6; blood pressure was 65/37; weight was 2.58kg; the head circumference was 32.5cm and the length was 48.0 cm. She was grunting, flaring, and retracting and had irregular respirations. There was central and circum-oral cyanosis. The liver was 2cm below the right costal margin. The rest of the physical exam was normal.

From the Newborn Division, Hinds General Hospital, Jackson, MS (Drs. Rawson and Friedman) and from the Department of Pediatric Radiology, University Medical Center, Jackson, MS (Dr. Blumenthal).

The WBC was 2,200 with 20 segmented neutrophils, 38 bands, 2 eosinophiles, 39 lymphocytes, 1 basophile and 22 nucleated rbcs. The hematocrit was 38.3, reticulocyte count 3.0% and platelet count 251,000. The blood glucose was 69 mg/dl, the BUN 7 mg/dl, creatinine 1.0 mg/dl, sodium 155 mEq/L, potassium 4.8 mEq/L, chloride 106 mEq/L and calcium was 7.0 mg/dl. A right radial arterial blood sample showed the PaO₂ 58.7 torr, PaCO₂ 38.0 torr, Ph 7.22, and bicarbonate 15.3 mEq/L breathing 70% oxygen. A urine specimen was normal. A chest x-ray was obtained.

DR. BLUMENTHAL: The chest x-ray obtained on admission showed bilateral coarse, nonspecific dense infiltrates consistent with congenital pneumonia (see Figure 1). There is no pneumomediastinum or pneumothorax and the bones and soft tissues are normal. Although the infiltrates are diffuse, they are too large and dense to be considered "miliary" infiltrates such as in congenital tuberculosis, and are nondiagnostic.



Figure 1. Chest x-ray obtained on admission shows bilateral coarse, nonspecific dense infiltrates consistent with congenital pneumonia.

DR. RAWSON: An umbilical artery catheter was inserted, and a solution of dextrose in water with supplemental calcium was begun. Ampicillin (150mg) and gentamicin (6.5mg) were given every 6 and 12 hours, respectively, and 2 mEq NaHCO₃ sodium bicarbonate were given intravenously. At 15 hours of age, a 250 ml whole blood exchange transfusion was performed. At 24 hours of age the blood culture taken at birth grew *Listeria monocytogenes*.

DR. FRIEDMAN: *Listeria monocytogenes* is an unusual cause of congenital pneumonia. This infant presented in much the same way as early-onset Group B streptococcal (GBS) sepsis presents. In fact, the clinical syndromes of early-onset GBS and early-onset listeriosis are clinically indistinguishable, with respiratory distress starting shortly after birth. Leukopenia is strongly associated with overwhelming infection. Dr. Rawson, what did you hope to accomplish with an exchange transfusion?

DR. RAWSON: We were assuming that this infant lacked specific and non-specific immune competence against GBS, which we thought was the cause of his pneumonia. By an exchange transfusion we hoped to replace immune factors, such as complement, immunoglobins and alternate pathway (properdin) components. We should note that definitive controlled studies concerning the efficiency of exchange transfusions on the outcome of sepsis in the newborn are lacking.

DR. FRIEDMAN: Infection with *Listeria* often produces a variety of toxic factors including a red cell hemolysin. The low hematocrit and increased numbers of nucleated red cells in this case may indicate that a hemolytic anemia was present. The presence of a 2 cm liver edge noted on physical examination could be attributed to overexpansion of the lung, but listeriosis, when well-established, produces miliary abscesses in the liver and other organs, a petechial skin rash and pharyngitis. The chest x-rays often show a destructive miliary-type of infiltrate pattern. Was there any evidence of other organ toxicity in this infant?

DR. RAWSON: There was no skin rash or pharyngitis. Liver enzyme tests were moderately elevated. The spinal fluid was clear, renal function was normal, and there was no objective evidence of myocardial toxicity.

The infant did require buffer for a metabolic acidosis, blood transfusion, and oxygen. Mechanical ventilation was not needed. The blood was sterilized and the hematologic and hepatic laboratory tests improved. We continued treating with ampicillin for 14 days and gentamicin for 10 days. She was discharged well to a more sanitary household.

DR. FRIEDMAN: Listeriosis in the perinatal period has been associated with unsanitary living conditions and exposure to farm animals, especially horses. Women in the third trimester may harbor the organism without illness, or have a syndrome of back and abdominal pain, fever, and chills, possibly present in this woman two weeks prior to delivery. Pregnant women may reacquire *Listeria* in each subsequent pregnancy, which may lead to repeated late trimester abortions. The infection has been called "Queen Ann's disease," since the English queen of the early 18th century, an avid horsewoman, is credited with multiple abortions, depriving the throne of an heir. In this century, claims that listeriosis is a disease acquired from horses or in unsanitary rural conditions are unsubstantiated, so that we must attribute the association of this woman with such conditions as coincidental.

Any infant suspected of early-onset GBS could actually have listeriosis since the two clinical syndromes are indistinguishable except in the laboratory. This baby's placenta should have been examined for evidence of listeriosis.

Both GBS and *Listeria* are sensitive to ampicillin and penicillin. Treatment should be extended for two to three weeks due to the risk of recurrence of listeriosis after a shorter treatment course. ★★★

1850 Chadwick Drive (39204)

Bibliography

1. Albritton, W. L., Wiggins, G. L. and Feeley, J. C.: Neonatal listeriosis: Distribution of serotypes in relation to age at onset of disease. *J. Pediatrics* 88:481-483, 1976.
2. Halliday, H. L. and Hirata, T.: Perinatal listeriosis: A review of twelve patients. *J. Obstet. and Gynec.* 133:405-410, 1979.
3. Remington, J. S. and Klein, J. O.: *Infectious Diseases of the Fetus and Newborn Infant*. W. B. Saunders Co., 1976.
4. McCracken, G. H. and Nelson, J. D.: *Antimicrobial Therapy for Newborns*. Grune and Stratton, 1979.

Radiologic Seminar CCXVIX: Intrarenal Colic — A Common Problem With an Unusual Presentation

RONALD P. SMITH, M.D. and

R. BRENT HARRISON, M.D.

Jackson, Mississippi

RENAL COLIC IS A COMMON condition encountered daily by both clinicians and radiologists. The radiographic findings of increased nephrogram, delayed pyelogram, and dilatation of the collecting system have been well described.¹ However, when the obstruction is within the kidney, rather than in the ureter, the radiographic findings may be confusing. We recently had the opportunity to study such a case, and the findings emphasize the importance of recognizing and evaluating this uncommon presentation of a very common condition.

Case History

This 50-year-old black man was in his usual state of good health until three days prior to admission, when he developed left sided costovertebral angle pain followed one day later by acute urinary retention. After admission he passed a urinary calculus (presumably urethral), which relieved his bladder symptoms; however, the costovertebral angle pain persisted for several more days. Urine cytology was negative for malignancy.

Plain film showed a single calcific density in the upper pole of the left kidney. The excretory urogram showed an upper pole calyceal obstruction in the area of the radiopaque calculi and an adjoining radiolucent defect at the infundibulum, thought probably due to clot or matrix formation (see Figure 1). Stone analysis, which revealed a core of 100% calcium oxylate and layers of 50% calcium oxylate and uric acid, suggested that the radiolucent defect may have represented urate deposition. Moderate



Figure 1a. Preliminary film of the excretory urogram demonstrates a small calcific density in the upper pole of the left kidney (arrow).



Figure 1b. Ten minute IVP film demonstrates slight fullness of the collecting system of the left upper pole as well as poor visualization of the infundibula to the left upper pole and a lucent filling defect in the left renal pelvis (arrow).

From the Department of Radiology, University of Mississippi Medical Center, Jackson, MS.



Figure 1c. Eight hour delay film demonstrates persistent opacification and mild dilatation of the obstructed portion of the collecting system.

dilatation of the affected calyx with a persistent upper pole nephrogram was noted. Retrograde pyelography showed similar findings (see Figure 2), and followup urograms showed resolution of the obstructive changes. The calculus identified on plain films persisted, but the radiolucent defect resolved. No surgery was performed.

Discussion

Renal calculi may be either the cause of or the result of urinary stasis. Renal colic may be produced by obstruction of the urinary collecting system at any level, including the calyx, as evidenced by this case. This emphasizes the fact that peristalsis involves the intrarenal collecting system as well as the ureter. While dilatation and delayed calyceal emptying are the more common signs of obstruction, the renal pelvis or calyces may occasionally appear smaller than normal due to spastic contractions.² Calyceal obstruction may have numerous etiologies, the most common being stricture, calculus, tumor, or peripelvic cyst.² Also, vascular structures have been shown to produce obstruction of the upper pole calyceal system by extrinsic pressure effect on the



Figure 2. Retrograde pyelogram demonstrates lucent defect in the infundibula to the dilated upper pole collecting system.

infundibulum. However, these are not usually accompanied by symptoms, delayed calyceal emptying, or increased nephrogram.³ ★★★

2500 North State Street (39216)

References

1. Paul, L. W. and Juhl, J. H.: Essentials of Roentgen Interpretation. Hagerstown, Harper and Row, 4th ed., 1981, 715.
2. Emmett, J. L. and Witten, D. M.: Clinical Urography. Philadelphia, Saunders, 3rd ed., 1971. Vol. I, 394, and Vol. II, 636-638.
3. Fraley, E. E.: Vascular obstruction of superior infundibulum causing nephralgia: a new syndrome. NEJM 275:1403-1409, 1966.

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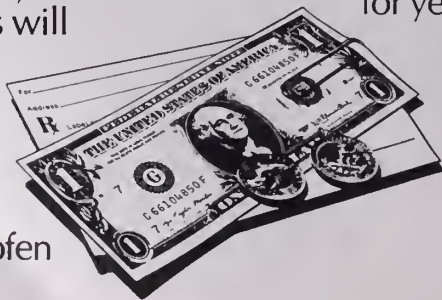
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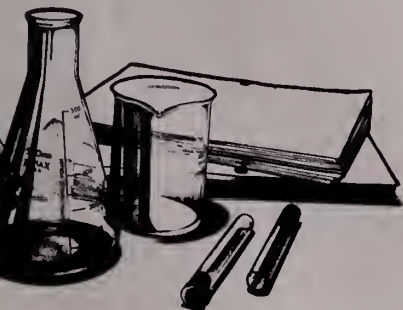
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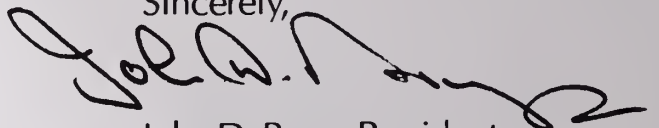
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CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see **WARNINGS**).

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In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: Coumarin-type anticoagulants. The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin. Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS

Incidence greater than 1%

Gastrointestinal: The most frequent adverse reaction is gastrointestinal (4% to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see **PRECAUTIONS**).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme. **Special Senses:** amblyopia (see **PRECAUTIONS**). **Hematologic:** leukopenia, decreased hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities. **Dermatologic:** alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** hemolytic anemia, thrombocytopenia, granulocytopenia bleeding episodes. **Allergic:** fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** gynecomastia, hypoglycemia. **Cardiovascular:** arrhythmias (Sinus tachycardia, bradycardia, and palpitations). **Renal:** decreased creatinine clearance, polyuria, azotemia.

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CAUTION: Federal law prohibits dispensing without prescription.

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The President Speaking

1982 — A Significant Year for Medicine

R. FASER TRIPLETT
Jackson, Mississippi

The year 1982 promises to be a significant one for medicine. Shortly after the second session of the 97th Congress convenes this month, we can expect the Reagan Administration's proposals for "pro-competition" or "consumer choice" legislation affecting health care. Indications are that these proposals will provide some type of tax incentives to both employers and employees who shop for less costly health care plans. First dollar insurance coverage of medical expenses will apparently become an idea whose time has passed. Basic health care for the needy will continue via Medicaid or some other type of government funded program, but even here as well as with Medicare, "consumer choice" will apparently provide an opportunity for recipients to select a plan of insurance coverage.

Later this year the Reagan Administration will face its first vote of public confidence when the entire U.S. House of Representatives and one-third of the U.S. Senate face reelection. The results of this election will bear heavily on the success of the administration for the next two years.

Our Mississippi Legislature will also be faced with some hard decisions on health programs when it convenes this month for its 1982 Regular Session. There will be fewer federal dollars which will require a response from the legislature either in the form of more state taxes or less state funded services. In any event the state will have to take a hard look at its current health care programs. Changes in federal requirements for the Medicaid program and new federal block grants for health programs will permit the state to design public supported health programs which more realistically address local needs. Hopefully, changes undertaken in this regard will be based upon careful demonstration and evaluation rather than some pie-in-the-sky scheme for a new health care utopia. There will be a need, too, for the public and private health sectors to carefully work together and to supplement rather than duplicate each other.

I urge you to inform yourselves and to be a participant in the many issues affecting medicine this year. ★★★

Cost Containment

Blue Cross recently sent out its appeal to all of us for cost containment. A California doctor is most critical when he is charged \$2,100 for the extraction of his child's four wisdom teeth, and the child was hospitalized for five hours. Another physician complains to a grievance committee when a very minor superficial laceration on his child resulted in a \$375 charge by the emergency room and the attending physician.

The doctor-lawyer from Colorado who is so active in malpractice remarks, "no doctor's time is worth \$1,000 an hour."

We all know that many times these charges are made because "insurance will pay." How quickly we would revert to reasonable charges if there were no third party.

The image of the profession isn't helped nor the malpractice threat lessened by charges that appear grossly excessive.

Let's try to keep the third party viable.

W. MONCURE DABNEY, M.D.
Editor

Medico-Legal Brief

PDR Not Liable To Consumer

The publisher of the *Physician's Desk Reference* has no obligation to perform its own testing to verify information submitted to it by drug manufacturers, a federal trial court in New York ruled.

A patient who allegedly became addicted to Valium filed suit against the manufacturer and the publisher of the *PDR*. She claimed that the manufacturer was grossly negligent in publishing information on Valium furnished by the manufacturer without first performing its own independent tests on Valium.

On its motion to dismiss the action, the publisher

argued that it was merely a conduit for the information and that it had no obligation to test the drug. It also contended that it could not be held liable for the patient's condition because it was not malicious, or reckless nor intended harm. Finally, it claimed that it had no duty under the First Amendment to test the drug.

Agreeing with the publisher's arguments, the trial court said that the descriptions of drugs carried in the *PDR* were advertisements. Libel and defamation cases decided by the U.S. Supreme Court held that a publisher was not liable for an advertisement unless the publisher showed reckless disregard for the truth. The publisher explicitly stated in the *PDR* that it published information furnished by manufacturers and did not advocate the use of any drugs. Moreover, the material published in the *PDR* was exactly the information approved for Valium by the Food and Drug Administration, the court said.

Since there was no allegation that the publisher knew of the addictive nature of Valium or acted in reckless disregard of the truth, the motion to dismiss was granted. — *Libertelli v. Hoffmann-La Roche, Inc.*, Docket No. 80 Civ. 5626 (D.C., N.Y., Feb. 20, 1981)

114th Annual Session

May 2-6, 1982

Mark Your Calendars Now

POSTGRADUATE CALENDAR

Jan. 16, 1982

ENDOCRINOLOGY OF THE AGING WOMAN
The Jackson Regency, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Obstetrics and Gynecology and the Medical Center Division of Continuing Health Professional Education.

Coordinator: G. William Bates, MD, associate professor of obstetrics and gynecology.

This seminar will present current concepts of menopause and emphasize indications and contraindications for hormonal replacement therapy. The physiology of ovarian failure and pathophysiology and estrogen deficiency will be covered. Fee: \$30. Credit: 3.5 credit hours in Category I of the AMA Physician's Recognition Award; AAFP credit applied for.

Jan. 23, 1982

PHOTOGRAPHY FOR EDUCATION AND SLIDE PROGRAMS
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Dentistry and the Medical Center Division of Continuing Health Professional Education.

Coordinator: William B. Akerly, DDS, UMC associate professor of restorative dentistry.

This program is open to physicians, dentists, teachers and hobbyists. Sessions will focus on macro-lens and close-up photography. Films, filters and reverse-text production techniques will be covered. Methods for graphic illustration and copying, such as polarization, glass supports and background materials, also will be demonstrated as a means for making effective title or lecture slides. Fee: \$50.

Feb. 4-5, 1982

RENAL UPDATE
Holiday Inn Downtown, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Medicine, the School of Nursing and the Medical Center Divi-

sion of Continuing Health Professional Education. Cosponsors are Kidney Care, Inc., the Kidney Foundation of Mississippi, the Mississippi Nephrologic Society and the Mississippi Urologic Society.

Coordinator: John D. Bower, M.D., professor of medicine (Nephrology) and director of the Artificial Kidney Unit, University of Mississippi School of Medicine.

Dr. Belding Scribner, a pioneer in chronic hemodialysis, will discuss the state of the art and future of renal replacement in this multidisciplinary symposium. Dr. Scribner is professor of medicine and chairman of the division of nephrology at the University of Washington in Seattle. An outstanding guest faculty will join him in presenting the program. Fee: \$50 for physicians. Credit: 11.5 contact hours (1.15 CEU), Category I of the AMA Physician's Recognition Award and the American Academy of Family Physicians.

March 11-13, 1982

SURGICAL FORUM IX
Holiday Inn Downtown, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Surgery and the Medical Center Division of Continuing Health Professional Education.

Coordinator: J. Harold Conn, M.D., professor of surgery, University of Mississippi School of Medicine, and chief of the division of surgery, Veterans Administration Medical Center.

An internationally recognized guest faculty will join Medical Center lecturers in presenting this program for the practicing surgeon. The program will include lectures, panel discussions with written questions from participants and breakfast conferences. Topics include surgical trauma, general surgery, a surgical update. Fee: \$250. Credit: 17 contact hours (1.7 CEU), Category I of the AMA Physician's Recognition Award. Advance registration is required.

FUTURE CALENDAR

March 25-26

FOURTH ANNUAL NEUROLOGY SPRING SYMPOSIUM
Holiday Inn Medical Center, Jackson

For more information on these and other seminars, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone (601) 987-4914.

MEDICAL ORGANIZATION

Board of Trustees Meets On MSMA Anniversary

The MSMA Board of Trustees held its regular fall meeting on the 125th Anniversary of the association. Meeting in Jackson on December 15, the Board commemorated the organizational meeting of the association in that same city on December 15, 1856.

In special recognition of the occasion the Board and officers of the association conducted ground-breaking ceremonies for a country doctor's office to be constructed at the new Agricultural and Industrial Museum on Lakeland Drive in Jackson. Joining the Board and officers for the event were Lt. Governor Brad Dye and officials of the Mississippi Agricultural Department.

In its official meeting, the Board acted on a comprehensive agenda to include adoption of a 1982

budget for the association totaling \$1,062,500 and including AMA dues of \$370,000. The Board particularly noted that this year marked the final payment on the MSMA office building in Jackson. The property and building, which had its initial construction in 1956 at a cost of some \$90,000 is now valued at over \$500,000.

In other actions, the Board voted to conduct a leadership conference for officers of state and county societies, state specialty groups and interested members on March 26, 1982 in Jackson.

The Board also acted to support programs for a poison control center and tertiary cancer center at the University Medical Center in Jackson after hearing presentations on behalf of these projects.

Following up on a referral from the Association's House of Delegates for the Board to study and recommend changes in the format for the annual scientific program of the association, the Board adopted a



MSMA Board members and officers attended ground-breaking ceremonies on December 15 for the country doctor's office to be constructed at the new Agricultural and Forestry Museum in Jackson. Among those who were present for the occasion are, from left, Dr. Lamar Weems of Jackson, Dr. Roy D. Duncan of Pascagoula, Dr. Joe Burnett of Oxford, Dr. Sidney Graves of Natchez, Dr. Boyce White of Laurel, Dr. R. Faser Triplett of Jackson, president, Lt. Gov. Brad Dye of Jackson, Dr. Whitman Johnson of Clarksdale, Dr. James O. Manning of Jackson, Dr. David Steckler of Natchez, Dr. Paul Moore of Pascagoula, and Bruce Hartfield, museum director.

report which will be presented to the House of Delegates at the 1982 MSMA Annual Session. The board also directed that the membership be polled to determine members' preferences for the annual session format.

In other activities the Board heard a report from the State Health Officer, Dr. Alton B. Cobb, concerning the health block grants recently enacted by Congress and planning by the Mississippi State Board of Health in this regard. The Board acted to formally express its concerns over the broad range of preventive and primary health services apparently being proposed by the State Board of Health for both indigent and non-indigent patients in response to the health block grants.

In legislative matters the Board acted to support legislation requiring child seat belt restraints, sponsored by the Mississippi Academy of Pediatrics, and to support legislation prohibiting the prescription of amphetamines for weight control, sponsored by the State Medical Licensing Board. The Board also went on record in support of the Homochitto Valley Medical Society's stand against the storage of hazardous wastes in Adams County.

The Board received for information reports dealing with the Interim Meeting of the AMA House of Delegates conducted in December, the MSMA Group Insurance Program, MMPAC membership, and private peer review by the Mississippi Foundation for Medical Care.

The Board established a committee to investigate the feasibility of establishing an on-going MSMA public relations campaign and authorized a poll of the membership to determine the feasibility of establishing a group health insurance program for members, their employees and families.

Attending the meeting were the following officers and members of the Board: Whitman B. Johnson, Jr., M.D., Clarksdale, Chairman; Ellis M. Moffitt, M.D., Jackson, Vice Chairman; W. Boyce White, M.D., Laurel, Secretary; W. Joseph Burnett, M.D., Oxford; William C. Gates, M.D., Columbus; William B. Hunt, M.D., Grenada; James O. Manning, M.D., Jackson; George L. Arrington, M.D., Meridian; David R. Steckler, M.D., Natchez; Roy D. Duncan, M.D., Pascagoula; R. Faser Triplett, M.D., Jackson, President; Sidney O. Graves, M.D., Natchez, President-Elect; Paul H. Moore, M.D., Pascagoula, Immediate Past President; J. Elmer Nix, M.D., Jackson, Secretary-Treasurer; Carl G. Evers, M.D., Jackson, Speaker of the House; and W. Lamar Weems, M.D., Jackson, Delegate to AMA.

Governor's Proclamation Recognizes MSMA Anniversary

A proclamation issued by Governor William Winter on November 17 recognizes the 125th Anniversary of the Mississippi State Medical Association and calls attention to the association's contributions toward better health care throughout Mississippi. The proclamation states:

Whereas, On December 15, 1981, the Mississippi State Medical Association will officially begin the one hundred twenty-fifth anniversary year of its founding; and

Whereas, The Mississippi State Medical Association has had a beneficial influence on cultivating and advancing medical knowledge; and

Whereas, The Mississippi State Medical Association has promoted public health and elevated standards of medical education and practice; and

Whereas, The Mississippi State Medical Association has directed public opinion with regard to the duties, responsibilities and requirements of the medical profession;

Now, Therefore, I, William F. Winter, Governor of the State of Mississippi, do hereby proclaim December 15, 1981-December 14, 1982, as Mississippi State Medical Association's 125th Anniversary Year in Mississippi and urge all Mississippians to recognize the many contributions made by Mississippi State Medical Association toward better health care for all citizens of Mississippi.

The association will commemorate the anniversary in various ways during 1982, including special activities planned for the 114th Annual Session in Biloxi, May 2-6.



Dr. Faser Triplett, left, MSMA President, and Dr. Whitman Johnson, Board of Trustees Chairman, prepare to burn the mortgage on the association's headquarters office building following the December Board meeting.



Dr. David Watson, University of Mississippi Medical Center professor of pediatrics and chairman of the Mississippi Chapter of the American Academy of Pediatrics, talks informally with the Claud L. Batson Memorial Lecturer Dr. James Nora, professor of pediatrics at the University of Colorado School of Medicine. His lecture, which concluded the two-day AAP program, was "Genetics: The New Medicine."

Dr. Jabaley Elected To Plastic Surgery Board

Dr. Michael E. Jabaley of Jackson has been elected to a three-year term on the American Board of Plastic Surgery. Dr. Paul Weeks of St. Louis and Dr. Eugene Courtiss of Boston were also elected to the board.

The 18-member board is responsible for examination and certification of all new plastic surgeons in Canada and the United States who have completed their residency training. It also administers a recertification examination every two years for surgeons who have already passed the certifying examination.

Dr. Jabaley, a graduate of the Johns Hopkins School of Medicine in Baltimore, Maryland, received his surgical training at Massachusetts General Hospital and Johns Hopkins Hospital. He is treasurer of the American Society for Surgery of the Hand. Dr. Jabaley formerly was chief of plastic surgery at the University of Mississippi Medical Center and now is in private practice in Jackson.

Are the results of
100 million worth of
government-funded research
on hypertension
worth reading about?





Dr. and Mrs. A. T. Tatum of Petal attended the opening of the West Jackson Family Medical Center on Henry Hill Drive in Jackson. The clinic is one of two model practice clinics for residents in the University of Mississippi Medical Center family medicine department. Dr. Marcia Newsom, third year resident assigned to the new clinic, acted as tour guide. Dr. Tatum, a family physician, and Mrs. Tatum are the parents of Dr. Nancy Tatum, a second year family medicine resident at UMC, also assigned to the clinic.



Faculty for the annual meeting of the Mississippi chapter of the American Academy of Pediatrics at the University of Mississippi Medical Center included from left, Dr. Donald MacDonald, pediatrician in private practice in Clearwater, Florida, and a national authority on drug abuse; Dr. Richard Andrassy, chief of general and pediatric surgery at Keesler Air Force Base, Biloxi; Dr. Paul Parker, UMC associate professor of pediatrics (gastroenterology); Dr. Thomas Christian, pediatric allergist in private practice in Jackson; Dr. James Nora, professor of pediatrics, University of Colorado School of Medicine and Claud L. Batson Memorial Lecturer; and Dr. Robert Abney, III, pediatrician in private practice in Jackson and program coordinator.

UMC Announces Staff Appointment

Dr. Winsor Verdon Morrison has been named professor of surgery and chief of the division of otolaryngology at the University of Mississippi Medical Center in Jackson.

Dr. Norman C. Nelson, UMC vice chancellor and dean of the School of Medicine, announced Dr. Morrison's October appointment following approval by the Board of Trustees, State Institutions of Higher Learning.

Dr. Morrison was chairman of the Department of Otolaryngology and Maxillofacial Surgery at the University of Tennessee and adjunct professor of audiology and speech pathology at Memphis State University before joining the Mississippi Medical Center faculty.

He also had served some 10 years on the Department of Otolaryngology faculty at the University of Washington in Seattle.

A former chief of the Department of Otolaryngology at the U.S. Public Health Service Hospital in Seattle, Dr. Morrison earned the BS degree at the University of Missouri and the M.D. at the University of Tennessee College of Medicine.

He took residency training in general surgery at the U.S. Public Health Service Hospital in Staten Island, New York, and in otolaryngology at Washington University in St. Louis.

A native of Zanol, Missouri, Dr. Morrison is a fellow of the American College of Surgeons and a member of the American Academy of Otolaryngology, the American Council of Otolaryngology and the American Rhinological Society.

Applications are now being accepted for

Scientific Exhibits

114th Annual Session

May 2-6, 1982

Biloxi Hilton

Space is limited. For information, write to

Chairman, Scientific Exhibits
P.O. Box 5229, Jackson, MS 39216

NEW MEMBERS

AIELLO, MARILYN J., Marks. Born Chicago, Apr. 24, 1937; M.D., University of South Alabama School of Medicine, Mobile, 1978; interned and family medicine, same, 1978-81; elected by Clarksdale and Six Counties Medical Society.

AINSWORTH, PATRICIA, Tupelo. Born Laurel, MS, Dec. 29, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned and psychiatry residency, University Medical Center, Jackson, 1974-78; elected by Northeast Mississippi Medical Society.

BEASLEY, JIMMIE L., Amory. Born Covington, TN, Sept. 16, 1938; M.D., University of Tennessee College of Medicine, Memphis, 1973; interned Baptist Memorial Hospital, Memphis, one year; pediatric residency, University of Tennessee, Memphis, 1975-76; neonatology fellowship, same, 1976-78; elected by Northeast Mississippi Medical Society.

BILLUPS, THOMAS K., Tupelo. Born Grenada, MS, Mar. 10, 1945; M.D., University of Alabama School of Medicine, Birmingham, 1975; interned and general surgery residency, University Medical Center, Jackson, 1975-80; vascular surgery fellowship, same, 1980-81; elected by Northeast Mississippi Medical Society.

BRUNI, RONALD T., Gulfport. Born Paterson, NJ, Dec. 26, 1941; M.D., George Washington University School of Medicine, Washington, DC, 1967; interned Buffalo Children's Hospital, Buffalo, NY, one year; pediatric residency, same, 1969-72; hematology fellowship, same, 1972-73; elected by Coast Counties Medical Society.

COOK, JAMES WALTER, Pearl. Born Jackson, MS, Dec. 9, 1939; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned University Medical Center, Jackson, one year; elected by Central Medical Society.

DANIEL C. RALPH, III, Jackson. Born Columbus, OH, Mar. 22, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned Uni-

In 1977, when
the Veterans Administration
compared Step-2
regimens in 450 mild
hypertensive patients,
which regimen was
proven most effective?



NEW MEMBERS / Continued

versity Medical Center, Jackson, one year; dermatology residency, University of Alabama Medical Center, Birmingham, 1978-81; elected by Central Medical Society.

DAIS RUSSELL ALAN, Oxford. Born Ft. Smith, AR, Dec. 2, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned and otolaryngology residency, University Medical Center, Jackson, 1975-79; elected by North Mississippi Medical Society.

DOSTER, VERNON W., Brookhaven. Born Winder, GA, July 17, 1948; M.D., Medical College of Georgia, Augusta, 1975; interned and ob-gyn residency, Pensacola Educational Program, Pensacola, FL, 1975-78; elected by South Central Medical Society.

EVANS, JOHN WILLIS, JR., Jackson. Born Memphis, Mar. 2, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned Brooke Army Medical Center, San Antonio, TX, one year; radiology residency, same, 1976-79; elected by Central Medical Society.

EWING, HENRY P., JR., Jackson. Born Abilene, TX, Oct. 22, 1946; M.D., University of Texas Southwestern Medical School, Dallas, 1974; interned, general surgery residency, and thoracic surgery residency, University Medical Center, Jackson, 1974-81; elected by Central Medical Society.

FOSTER, JOHN P., Jackson. Born Houston, MA, Aug. 20, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and family medicine residency, University Medical Center, Jackson, 1978-81; elected by Central Medical Society.

GARRETT, ROBERT L., Greenwood. Born Silver Creek, MS, Dec. 7, 1942; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned and anesthesiology residency, University Medical Center, Jackson, 1976-77; fellowship anesthesiology, Ochsner Foundation Hospital, New Orleans, 1977-79; elected by Delta Medical Society.

GORMAN, DOUGLAS E., Jackson. Born New Brunswick, Canada, July 29, 1948; M.D., Dalhousie University Faculty of Medicine, Halifax, Nova Scotia, 1974; interned Wellesley Hospital, Toronto, one year; general surgery residency, Michaels Hospital, Toronto, 1975-76 — Hospital for Sick Children, University New York Hospital, Stony Brook, NY, 1976-78 — Veterans Hospital, Northport, NY (plas-

tic surgery) 1978; plastic surgery residency, University Medical Center, Jackson, 1978-80; elected by Central Medical Society.

GUILD, DONALD C., Jackson. Born New York, NY, June 16, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1971; interned and psychiatry residency, University Medical Center, Jackson, 1971-74; elected by Central Medical Society.

HAMILTON, EDWARD C., Gulfport. Born Mobile, AL, Dec. 8, 1922; M.D., Vanderbilt University School of Medicine, Nashville, 1946; interned Vanderbilt Hospital, Nashville, one year; general surgery residency, V. A. Hospital, Nashville, 1949-53; elected by Coast Counties Medical Society.

HEMSTREET, GEORGE P., III, Jackson. Born Aruba, Netherlands, Sept. 29, 1941; M.D., Hahnemann Medical College and Hospital, Philadelphia, PA, 1968; interned University of Oklahoma, Oklahoma City, one year; general surgery residency, same, 1968-70; urology residency Duke University Medical Center, Durham, NC, 1973-76; Ph.D., microbiology and immunology, same, 1970-73; elected by Central Medical Society.

HENSARLING, JAMES K., Jackson. Born Hattiesburg, MS, June 11, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned, internal medicine residency, and fellowship rheumatology, University Medical Center, Jackson, 1975-80; elected by Central Medical Society.

HINDMAN, STEPHEN H., Jackson. Born Meridian, MS, Sept. 12, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned University of California at San Francisco, 1973-74; internal medicine residency, University Medical Center, Jackson, 1977-79; cardiology fellowship, same, 1979-81; elected by Central Medical Society.

HOWELL, GEORGE E., II, Jackson. Born New Orleans, Dec. 21, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned and surgery residency, Vanderbilt University, Nashville, 1975-79; elected by Central Medical Society.

JAMES, ALTON B., Oxford. Born Montgomery, AL, Apr. 1, 1947; M.D. University of Alabama School of Medicine, Birmingham, 1975; interned and internal medicine residency, University of South Alabama, Mobile, 1975-80; elected by North Mississippi Medical Society.

KING, MICHAEL LEWIS, Oxford. Born Louisville, MS, Mar. 1, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned and general surgery residency, University of South Alabama Medical Center, Mobile, 1976-81; elected by North Mississippi Medical Society.

KUKORA, JOHN S., Jackson. Born Detroit, MI, Sept. 13, 1948; M.D., University of Michigan Medical School, Ann Arbor, 1973; interned and general surgery residency, University of Michigan, Ann Arbor, 1973-79; elected by Central Medical Society.

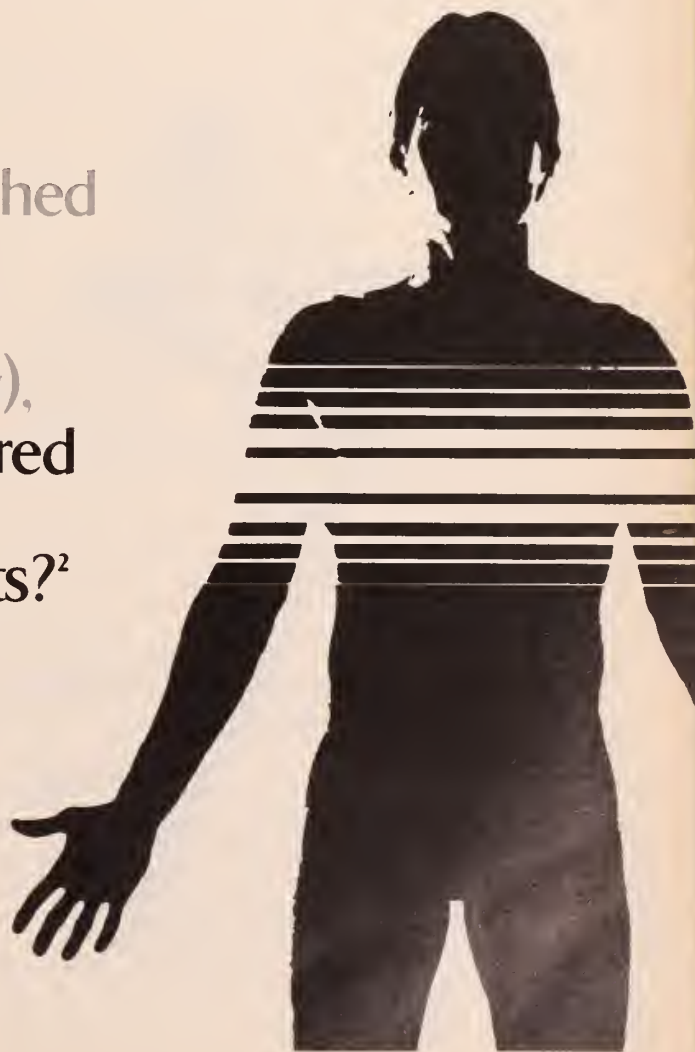
LONG, BILLY WAYNE, Jackson. Born Tupelo, MS, Apr. 5, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned and internal medicine residency, University Medical Center, Jackson, 1973-75; internal medicine residency, National Institute of Health, Bethesda, MD, 1975-77; gastroenterology fellowship, University of Pennsylvania, Philadelphia, 1977-79; elected by Central Medical Society.

MATHERNE, PAUL G., Biloxi. Born New Orleans, Sept. 13, 1952; M.D., Louisiana State University School of Medicine, Shreveport, 1978; interned and family practice residency, Long Hospital, Baton Rouge, 1978-81; elected by Coast Counties Medical Society.

MCCRARY, RICHARD B., Gulfport. Born Tulsa, OK, Mar. 16, 1952; M.D., University of Arkansas School of Medicine, Little Rock, 1978; interned and pediatric residency, University of Arkansas, Little Rock, 1978-81; elected by Coast Counties Medical Society.

McKINLEY, ROBERT L., JR., Jackson. Born Meridian, MS, Nov. 25, 1929; M.D., University of Mississippi School of Medicine, Jackson, 1958; interned Nashville General Hospital, Nashville, 1958-59; psychiatry residency, Menninger School of Psychiatry, Topeka, KS, 1962-64; elected by Central Medical Society.

In 1979, when results were published for the five-year, 10,000-patient Hypertension Detection and Follow-up Program (HDFP study), which Step-2 regimen was preferred and was deemed effective without significant adverse effects?²

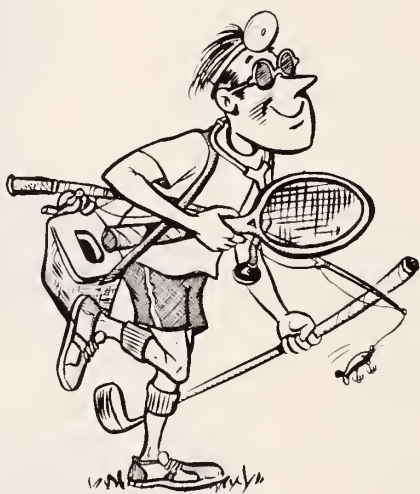


NEW MEMBERS / Continued

MILHORN, HOWARD T., JR., Jackson. Born Kingsport, TN, Oct. 30, 1936; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned and family practice residency, University Medical Center, Jackson, 1977-80; elected by Central Medical Society.

MOSES, WALTER CARL, JR., Greenwood. Born Greenwood, MS, June 9, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and internal medicine residency, Methodist Hospital, Memphis, 1978-81; elected by Delta Medical Society.

PACE, WILLIAM LEWIS, SR., Hattiesburg. Born Forest, MS, Feb. 22, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned and ob-gyn residency, University Medical Center, Jackson, 1977-81; elected by South Mississippi Medical Society.



Tennis Deep Sea Fishing Golf Jogging

These tournaments are just a few of the special activities on the schedule for MSMA's 114th Annual Session.

Plan Now to Attend!

PITTMAN, H. WAYNE, Tylertown. Born Columbia, MS, Oct. 7, 1950; M.D., Loma Linda University School of Medicine, Loma Linda-Los Angeles, CA, 1976; interned and diagnostic radiology, same, 1977-81; elected by South Central Medical Society.

REAGAN, MORRIS T., Jackson. Born Hazlehurst, MS, Dec. 22, 1935; M.D., Medical College of Wisconsin, Milwaukee, 1976; interned Indiana University, Indianapolis, IN, 1976-77; radiation therapy residency, Medical College of Wisconsin, Milwaukee, 1977-80; elected by Central Medical Society.

REDDY, SANTHOSA, Tylertown. Born India, Apr. 20, 1947; M.D., Kakatiya Medical College, Warangal, Andhra Pradesh, India, 1973; interned Arthur C. Logan Memorial Hospital, New York, one year; medicine residency, St. John's Episcopal Hospital, Brooklyn, NY, 1977-78; medicine residency, V. A. Hospital, Dayton, OH, 1978-79; elected by South Central Medical Society.

REED, ROGER H., Gulfport. Born Clayton, MO, Feb. 25, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned Keesler AFB Hospital, Biloxi, one year; elected by Coast Counties Medical Society.

RIVLIN, MICHEL E., Jackson. Born Aliwal North, South Africa, July 21, 1935; M.D., University Witwatersrand, South Africa, 1957; interned Johannesburg General Hospital, South Africa, 1958-59; ob-gyn residency, London, England, 1959-1962; ob-gyn residency University Medical Center, Jackson, 1978-79; elected by Central Medical Society.

SPENCER, DAVID LAMAR, Pascagoula. Born Bonifay, FL, Feb. 21, 1950; M.D., Tulane University School of Medicine, New Orleans, 1976; interned and general surgery residency, Tulane, New Orleans, 1976-81; elected by Singing River Medical Society.

SPRABERRY, DONALD LEE, Long Beach. Born Tupelo, MS, March 3, 1947; M.D., Kansas City College of Osteopathy and Surgery, Kansas City, MO, 1976; interned and anesthesiology residency, Pontiac Osteopathic Hospital, Pontiac, MI, 1976-79; elected by Coast Counties Medical Society.

STUDDARD, JOHN ENGLISH, Jackson. Born Jackson, MS, Oct. 5, 1951; M.D., University of Mississippi

School of Medicine, Jackson, 1976; interned, medicine residency, and pulmonary fellowship, Mayo Graduate School of Medicine, Rochester, MI, 1976-81; elected by Central Medical Society.

SUTHERLAND, WILLIAM KENNETH, Jackson. Born El Paso, TX, Aug. 28, 1944; M.D., University of Texas Medical Branch, Galveston, TX, 1970; interned Wesley Medical Center, Wichita, KS, 1970-71; ob-gyn residency, Brooke Army Medical Center, San Antonio, 1972-75; elected by Central Medical Society.

TORRES, ESTHER G., Marks. Born Philippines, June 22, 1946; M.D., Faculty of Medicine and Surgery University of Santo Tomas, Manila, Philippines 1971; interned Santo Tomas University Hospital, Philippines, one year; anesthesiology residency Johns Hopkins, Baltimore, 1977-79; anesthesiology residency, Montefiore Hospital, 1979-80; elected by Clarksdale and Six Counties Medical Society.

WADE, JOHN DAVID, Jackson. Born Hattiesburg, MS, Dec. 26, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned and radiology residency, University Medical Center, Jackson, 1977-81; elected by Central Medical Society.

WAHAB, SALIM, Tunica. Born Tayila, Pakistan, Apr. 3, 1936; M.D., Nishter Medical College, Pakistan, 1961; interned St. Thomas Hospital, Akron, OH, one year; general surgery residency, Harlan Appalachian Hospital, Harlan, KY, 1971-75; elected by Clarksdale and Six Counties Medical Society.

WEATHERSBY, PATRICIA, Coahoma. Born Coahoma, MS, Feb. 2, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned and radiology residency, University Medical Center, Jackson, 1977-81; elected by Clarksdale and Six Counties Medical Society.

In 1980, when the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure published their recommendations, which Step-2 regimen best met their criteria for effectiveness, safety, simplicity of titration, convenience, and economy?³



PERSONALS

The American Academy of Family Physicians recently recognized six MSMA members (W. T. MAYER of McComb, J. F. ECKFORD of Starkville, ORVILLE P. STONE of Ripley, A. T. TATUM of Hattiesburg, DAVID HENRY THORNHILL of Gloster, and GUY T. VISE, SR. of Meridian) for a quarter-century of membership and service.

ORLANDO ANDY of UMC presented papers at the 12th World Congress of Neurology and the Epilepsy International Congress, both in Japan, and presented papers at the Southern EEG Society meeting in Orlando, Florida.

JOHN BISE of Jackson recently attended the 4th World Congress on Cervical Pathology and Colposcopy in London, England.

EDGAR E. BOBO of Pearl has been recertified as a diplomate of the American Board of Family Practice.

DAVID BYRNE announces the opening of his office for the practice of general and vascular surgery at 641 Dunbar in Bay St. Louis.

JAMES M. CADE has associated with Emergency Physicians of Hattiesburg.

ROBERT DONALD of Pascagoula has been named chief of staff for Singing River Hospital. Other officers are F. J. SELMAN, chief-elect, and E. S. HOFFMAN, secretary-treasurer.

EDGAR DRAPER of UMC presented a paper at the Medical College of Georgia and lectured at Fort Gordon Air Force Base in Augusta, Georgia.

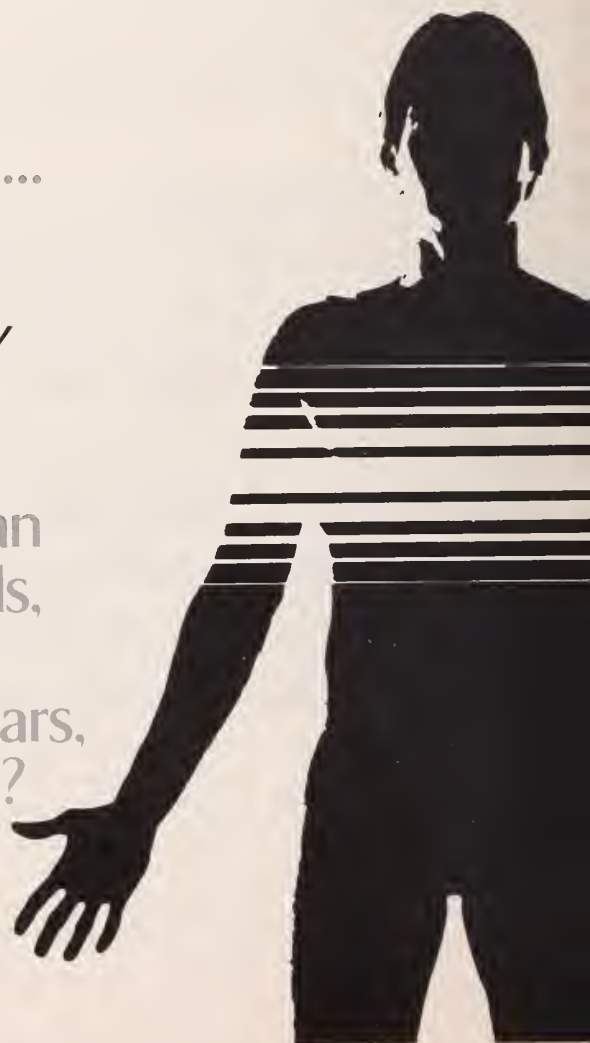
JOHN DYER of Houston received the "Book of Golden Deeds" award from the Houston Exchange Club for service to the community.

TOMAS R. FLORES announces the opening of his office for the practice of orthopedic surgery at 797-A Dunbar Avenue in Bay St. Louis.

Believe it or not, doctor,
it's the combination found in...

Salutensin[®]
(hydroflumethiazide 50 mg/
reserpine 0.125 mg)

And don't the results of more than
\$100 million worth of clinical trials,
involving thousands of patients
who were followed for several years,
merit your serious consideration?



ELMO P. GABBERT of Meadville has been recertified as a diplomate of the American Board of Family Practice.

JAMES GRACE of Ocean Springs has been named chief of staff for Ocean Springs Hospital. Other officers are LYMAN J. SCRIPTER, chief-elect, and C. H. ALLEN, secretary-treasurer.

JAMES C. GRAHAM of Enterprise was named the 1981 Honor Alumnus by the Jones County Junior College Alumni Association.

SIDNEY O. GRAVES has been elected president of the Natchez Rotary Club.

DONALD C. GUILD and ROBERT L. MCKINLEY, JR., both of Jackson announce the opening of their office for the practice of general and forensic pathology at 1900 Dunbarton, Suite B.

ARMIN HAERER of UMC presented a paper at a meeting of the Society of Clinical Neurologists in Lake George, New York.

RICHARD HUTCHINSON of UMC recently served as consultant to the National Heart, Lung and Blood Institute research review committee in Washington, DC.

HERBERT LANGFORD of UMC was guest speaker at the Argentina Cardiovascular Association meeting in Buenos Aires.

JOHN M. MCRAE has opened his practice of general surgery, with offices at 608 2nd Avenue in Laurel.

RODNEY MEEKS of UMC presented a paper at the Southern Medical Association meeting in New Orleans and was guest speaker at the Medical College of Georgia in Macon, Georgia.

THOMAS S. MESSER, JR., of Hattiesburg has opened his office for the practice of cardiology at 710 S. 28th Avenue.

JOHN MORGAN of McComb is the new chief of staff at Southwest Mississippi Regional Medical Center. Other officers are BERT BRADFORD, chief-elect, and WILLIAM MEYER, secretary-treasurer.

And there's more proof on the way!

1982 will see the completion of the Multiple Risk Factor Intervention Trial (MRFIT)—a six-year, 12,000-patient study assessing the factors that increase risk of cardiovascular disease. For the management of hypertension, the preferred step-2 regimen in this study is reserpine-thiazide.

In 1978, in a preliminary report presented to the Epidemiology Section of the American Heart Association (Dallas, Nov 1978), after 12 months of the trial, fewer patients (5.3%) treated with reserpine suffered depression than even the untreated control group (7.7%)!

See references and brief summary of prescribing information on last pages of this advertisement.

Place this coupon in an envelope and send it to:

BRISTOL LABORATORIES
Division of Bristol-Myers Company
3700 W. Genesee Street
Syracuse, New York 13219

Please provide me with:

- ☐ Clinical samples of Salutensin® (hydroflumethiazide 50mg/reserpine 0.125mg) and Salutensin-Demi™ (hydroflumethiazide 25mg/reserpine 0.125mg)
☐ Journal article reprints of the clinical studies mentioned in this ad

Name (please print) _____

Address _____

City _____

State _____

Zip _____

Signature _____

CUT HERE—FILL OUT—CUT HERE—FILL OUT

SM-2348

11/81

PERSONALS / Continued

MARIO PINEDA of Jackson was principal lecturer at the 15th National Congress of Neurology, Psychiatry and Hygiene at the University of Campinas in Brazil.

J. R. POWELL of West Point recently spoke to the West Point Kiwanis Club on the subject of his mission trip to Honduras with Global Outreach.

THOMAS R. POUNDS has associated with Walley's Clinic in Waynesboro for the practice of general medicine.

PHIL RHODES of UMC presented a paper at the American College of Obstetrics and Gynecology meeting in Kansas City, Missouri.

CALVIN L. SCHUSTER announces the opening of his office for the practice of general surgery at 348 Crossgates Boulevard in Brandon.

DWALIA SOUTH has associated with Ripley Medical Clinic for the practice of family medicine.

WILLIAM H. SPRAGINS of Greenville has been named a fellow of the American Academy of Family Physicians.

ROBERT J. TRAUTMAN, JR., announces the opening of his office for the practice of dermatology at 2200 S. Lamar in Oxford.

MARY WARD of Corinth is the new chief of staff at Magnolia Hospital.

DAVID WATSON of UMC attended the 1981 American Academy of Pediatrics chapter chairman's forum in Chicago as Mississippi chapter chairman.

LAMAR WEEMS of UMC presented a paper at the Southern Medical Association meeting in November and attended a planning meeting in New Orleans for the Southeastern Section annual meeting of the American Urological Association.

WINFRED WISER of UMC was a roundtable discussion leader during the District VII meeting of the American College of Obstetricians and Gynecologists in Kansas City, Missouri.

Salutensin® Salutensin-Demi™

(Hydroflumethiazide, Reserpine Antihypertensive Formulation)

Brief Summary of Prescribing Information (12) 10/27/78

For complete information consult Official Package Circular.

WARNING

This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

CONTRAINDICATIONS

Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

WARNINGS

Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or

without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients.

Use in Pregnancy

Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

PRECAUTIONS

Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia

(especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

JOHN D. WOFFORD of Jackson announces the association of DAVID O. WESTBROOK for the practice of internal medicine and pulmonary medicine.

RAUL E. VALENZUELA of Jackson announces the relocation of his office for diseases and surgery of the retina to Doctors Hospital Medical Plaza, 2969 University Drive.

DEATHS

MILLER, W. E., Jackson. Born Mississippi, Aug. 31, 1903; M.D., University of Illinois College of Medicine, Chicago, 1931; interned University of Illinois, Chicago, one year; died Oct. 13, 1981, age 78.

STEWART, G. B., Picayune. Born Carriere, MS, Jan. 11, 1910; M.D., Tulane University School of Medicine, New Orleans, 1944; interned Touro Infirmary, New Orleans, 1944; surgery residency, same, 1944-46; died Oct. 3, 1981, age 71.

Review A Book

The following books have been received by the MSMA Headquarters Office. Medical readers (members of MSMA) interested in reviewing any of these volumes should address their requests to Editor, THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION, P. O. Box 5229, Jackson 39216. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to the JOURNAL a review for publication.

Current Surgical Diagnosis & Treatment. 5th edition. By J. Englebert Dunphy, M.D., Lawrence W. Way, M.D., Los Altos: Lange Medical Publications, 1981. \$25.00.

Review of Medical Physiology. 10th edition. By William F. Ganong, M.D., Los Altos: Lange Medical Publications, 1981. \$17.00.

Nutrition and Medical Practice. By Lewis A. Barnes, M.D., Yank D. Coble, Jr., M.D., Donald I. Macdonald, M.D., and George Christakis, M.D., M.P.H., Westport, CT: AVI Publishing Co., 1981.

ADVERSE REACTIONS

Hydroflumethiazide

Skin-rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation.

Reserpine

Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares.

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1 tablet b.i.d.

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References:

1. Propranolol in the treatment of essential hypertension. Veterans Administration Cooperative Study Group on Antihypertensive Agents. *JAMA* 237:2303-2310, 1977.
2. Five-year findings of the hypertension detection and follow-up program: I. Reduction in mortality of persons with high blood pressure, including mild hypertension. Hypertension Detection and Follow-up Program Cooperative Group. *JAMA* 242:2562-2571, 1979.
3. The 1980 Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med* 140:1280-1285, 1980.

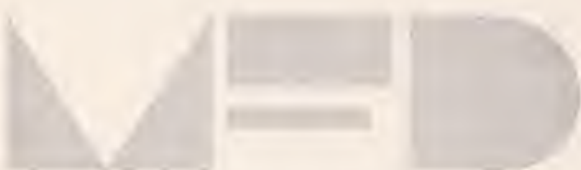
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Hal Robinson Joins MMFES Staff



Halford (Hal) B. Robinson has joined the staff of the Mississippi Medical Fraternal and Educational Society, Inc. as controller. A graduate of Mississippi State University with a B.S. degree in accounting, Robinson is currently completing requirements for the Master of Business Administration degree from Mississippi College. He is a member of the National Association of Accountants. He and his wife, the former Janie Warnock of Vicksburg, have two children.



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UMC Schedules Annual Surgical Forum

The University of Mississippi Medical Center will host the ninth annual Surgical Forum March 11-13, 1982, at the Holiday Inn Downtown in Jackson.

Sponsors are the University of Mississippi School of Medicine Department of Surgery and the Medical Center Division of Continuing Health Professional Education. Dr. James D. Hardy is professor and chairman of the department of surgery at the Mississippi Medical Center.

An outstanding guest faculty will join Mississippi Medical Center faculty members in presenting the sessions.

Sessions will include advances in burn management, practical ICU monitoring of the critically ill patient, newer techniques in anesthesia, nutritional assessment and treatment of surgical patients, and updates in organ transplantation, pediatric surgery and orthopaedics.

Course fee is \$250. The program meets criteria for 17 credit hours in Category I of the Physician's Recognition Award of the American Medical Association. Advance registration is required.

For information, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone: (601) 987-4914.

Memorial Hospital at Gulfport Will Host Symposium

"Surgical Care at the Medical Center — Tulane Medical Center" is the topic of a symposium to be presented January 30 at Memorial Hospital at Gulfport.

Members of the faculty of Tulane University School of Medicine will present lectures on "Management of Thoracic Trauma," "Sepsis in the Surgical Patient," "Advances in Adjunctive Therapy of Breast Cancer," "Initial Management of the Traumatized Patient," and "Clinical Renal Transplantation."

The Consortium of Gulf Coast Community Hospital and Memorial Hospital at Gulfport is sponsoring the symposium. For more information write to the symposium coordinator, Arthur M. Matthews, Jr., M.D., P.O. Box 1810, Gulfport, MS 39501, or call (601) 863-1441.

MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 13-17, 1982, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

State and Local

Mississippi State Medical Association, 114th Annual Session, May 2-6, 1982, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, June 30-July 3, 1982, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. J. Barry Gilbert, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Robert L. Coggin, Pres. and Secy., 965 Avent Dr., Grenada 38901. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, State, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March,

June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Albert H. Laws, Secy., 816 Second Ave. North, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, February, May, August, November. Robert D. Holbert, Secy., P.O. Box 1502, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Douglas F. Thomas, Secy., 415 South 28th Ave., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly
Mississippi State Medical Association
735 Riverside Drive
Jackson, MS 39216

North Mississippi Medical Center
830 Gloster Avenue
Tupelo, MS 38801

Forrest General Hospital
Box 1897
Hattiesburg, MS 39401

Mississippi Baptist Hospital
1225 N. State Street
Jackson, MS 39201

Gulf Coast Community Gulfport
Memorial Hospital Consortium
4642 W. Beach Boulevard
Biloxi, MS 39531

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Delta Medical Center
Greenville, MS 38701

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Biloxi Regional Medical Center
1559 Lafayette St.
Biloxi, MS 39533

Mississippi Radiological Society
316 Medical Arts Building
Jackson, MS 39201

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

Mercy Regional Medical Center
100 McAuley Drive
Vicksburg, MS 39180

North Panola County Hospital
Drawer 160
Sardis, MS 38666

Singing River Hospital
2809 Denny Avenue
Pascagoula, MS 39567

Magnolia Hospital
Alcorn Drive
Corinth, MS 38834

Greenwood Leflore Hospital
1508 Leflore Avenue
Greenwood, MS 38930

PLACEMENT SERVICE

Situations Wanted

BOARD ELIGIBLE ANESTHESIOLOGIST seeks practice location. M.D. from M. P. Shah Medical College, Jamnagar, India, 1971. Anesthesiology residency at University of Tennessee, 1980. Married. Contact Mohanlal L. Patel, M.D., 5289 Queen Anne Dr., Memphis, TN 38134.

PEDIATRICIAN completing military obligation in November seeks practice opportunity in single specialty, multi-specialty or partnership position in community of 20,000-80,000 population. Contact David W. Drennen, M.D., 9998A Saint Onge Avenue, Ellsworth AFB, SD 57706.

PEDIATRICIAN seeks practice location upon completion of residency in July 1981. Contact J. K. Angrish, M.D., 1222 Vincent Ct., #4, Flint, MI 48503.

SURGEON seeks location in general thoracic and cardiac surgery upon completion of residency in July, 1982. Graduate of Tulane University, 1975. Contact Dr. Kevin M. Keubler, 600 Highland Ave., Madison, WI 53792.

PHYSICIAN completing radiology residency in June 1982 seeks location with private community hospital. Graduate of Harvard. Contact Dr. Eugene B. Rosenberg, Mount Sinai Medical Center, 4300 Alton Road, Miami Beach, FL 33140.

PHYSICIAN completing pathology residency in September 1982 seeks location with pathology group with emphasis on surgical pathology. Graduate of University of Tennessee School of Medicine. Contact Dr. William D. Crump, 1027-B Beacon Parkway East, Birmingham, AL 35209.

PHYSICIAN completing pathology residency in June 1982 seeks group or partnership. Graduate of University of Mississippi School of Medicine. Contact Dr. Walton L. Moore, Department of Pathology, University of Alabama, Birmingham, AL 35294.

PATHOLOGIST — Board Eligible. University trained. Completing residency. Available July 1981. Contact Ashraf Mohammad, M.D., University Medical Center, 2500 North State St., Jackson, MS 39216.

CARDIOLOGIST seeks solo or group practice opportunity in hospital-based consultative practice. Completing fellowship in June 1981. Contact Amar De-Sai, M.D., 1003 Fenley Ave., Louisville, KY 40222.

PEDIATRICIAN and PATHOLOGIST (husband and wife) seek practice opportunity. Available July 1981. Contact Michael M. Lessner, M.D. and Evelyn J. Diehl, M.D., 1920 Cheremoya Ave., Los Angeles, CA 90068.

PATHOLOGIST especially interested in coagulation and blood banking seeks hospital-based position. Contact Daniel Williams, Jr., M.D., 77 Rippowam Rd., Apt. A, Stamford, CT 06902.

GENERAL PRACTITIONER seeks practice location in small community. Contact Keith Hummell, M.D., 405 Mesaba Ave., Apt. 5C, Duluth, MN 55806.

OPHTHALMOLOGIST seeks practice location upon completion of military service in January 1982. Contact John R. Wood, M.D., 8430 Rocky Path, San Antonio, TX 78250.

BOARD ELIGIBLE INTERNIST seeks practice location; M.D. from University of Texas at Southwestern. Contact Stephen R. Cherry, M.D., 7061 B Creekview Trail, St. Louis, MO 63123.

BOARD ELIGIBLE PATHOLOGIST seeks practice opportunity. Graduate of University of Mississippi School of Medicine; residencies. UMC. Contact Marianna G. Pardue, M.D., 315 Cedarwood, Jackson, MS, 39212.

BOARD CERTIFIED FAMILY PRACTITIONER seeks practice location. Currently completing military obligation and available 7/82. Contact John E. Bailes, Jr., M.D., 5405 Hackney Circle, Bossier City, LA 71111.

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ANESTHESIOLOGIST. Fee-for-service professional corporation seeking a board-eligible anesthesiologist immediately to join another anesthesiologist and 3 CRNA; university town, 150-bed hospital. Send CV to Anesthesiology Consultants P.A., P.O. Box 794, Oxford, MS 38655 or call (601) 234-6000.

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IN CONCLUSION

Nationwide figures for 1981 "clearly indicate that the honeymoon is over for the physician-owned companies writing medical liability insurance..." said Dr. James Sammons, Executive Vice President of the AMA, during the Forum for Medical Affairs in Las Vegas, Dec. 6. Although the frequency and severity of claims are increasing at an alarming rate, Dr. Sammons urged continued support of physician-owned companies. He noted that 45% of the national market is covered by such companies. Speakers from several states reported increasing claims.

The AMA is planning follow-up activities to its recent Conference on Increased State Responsibility for Health Programs. Designed to maintain leadership for organized medicine's involvement with the shifting of substantial health program responsibility to the states, the activities will include: increasing liaison with various organizations representing state governments; periodic surveys of states to determine approaches on block grant implementation and Medicare changes; and assistance in developing legislative proposals.

The Department of Health and Human Services will soon be issuing proposed regulations setting new rates for Medicare kidney dialysis reimbursement, says a recent news report. The proposal contains a two-tiered reimbursement system with one rate for hospital-based facilities (\$133) and a different rate for independent, free-standing treatment centers (\$128). Currently there is a single rate of \$138 per dialysis regardless of where it is performed. The proposal will include greater incentive for home dialysis.

A bill to "amend the FTC Act to protect the legislative and regulatory authority of state legislatures" was introduced on the last day of the first session of the 97th Congress. S 1984 is similar to a draft bill developed by the AMA. It would exclude state regulated professions and their associations from FTC jurisdiction. In addition, the bill would more clearly state FTC jurisdiction by redefining the term "unfair competition." The bill was referred to the Senate Commerce, Science and Transportation Committee.

Best Wishes for a Happy New Year

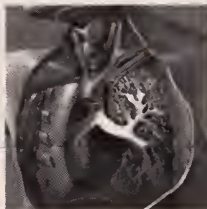
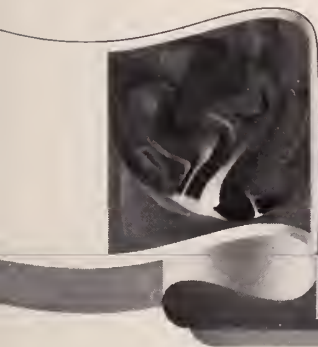
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Bactrim is useful for the following infections when due to susceptible strains of indicated organisms (see indications section in summary of product information):

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multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarthritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage. 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100, Tel-E-Dose[®] packages of 100: Prescription Paks of 20 and 28. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose[®] packages of 100: Prescription Paks of 40. Pediatric Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).



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Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. **Note:** The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to penicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonia. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBCs are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: General: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema

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Bactrim continues to demonstrate high clinical effectiveness in recurrent urinary tract infections. Bactrim reaches effective levels in urine, serum, and renal tissue¹...the trimethoprim component diffuses into vaginal secretions in bactericidal concentrations¹... and in the fecal flora, Bactrim effectively suppresses Enterobacteriaceae^{1,2} with little resulting emergence of resistant organisms.

1. Rubin RH, Swartz MN: *N Engl J Med* 303:426-432, Aug 21, 1980. 2. Data on file, Medical Department, Hoffmann-La Roche Inc.

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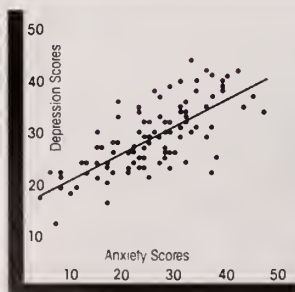
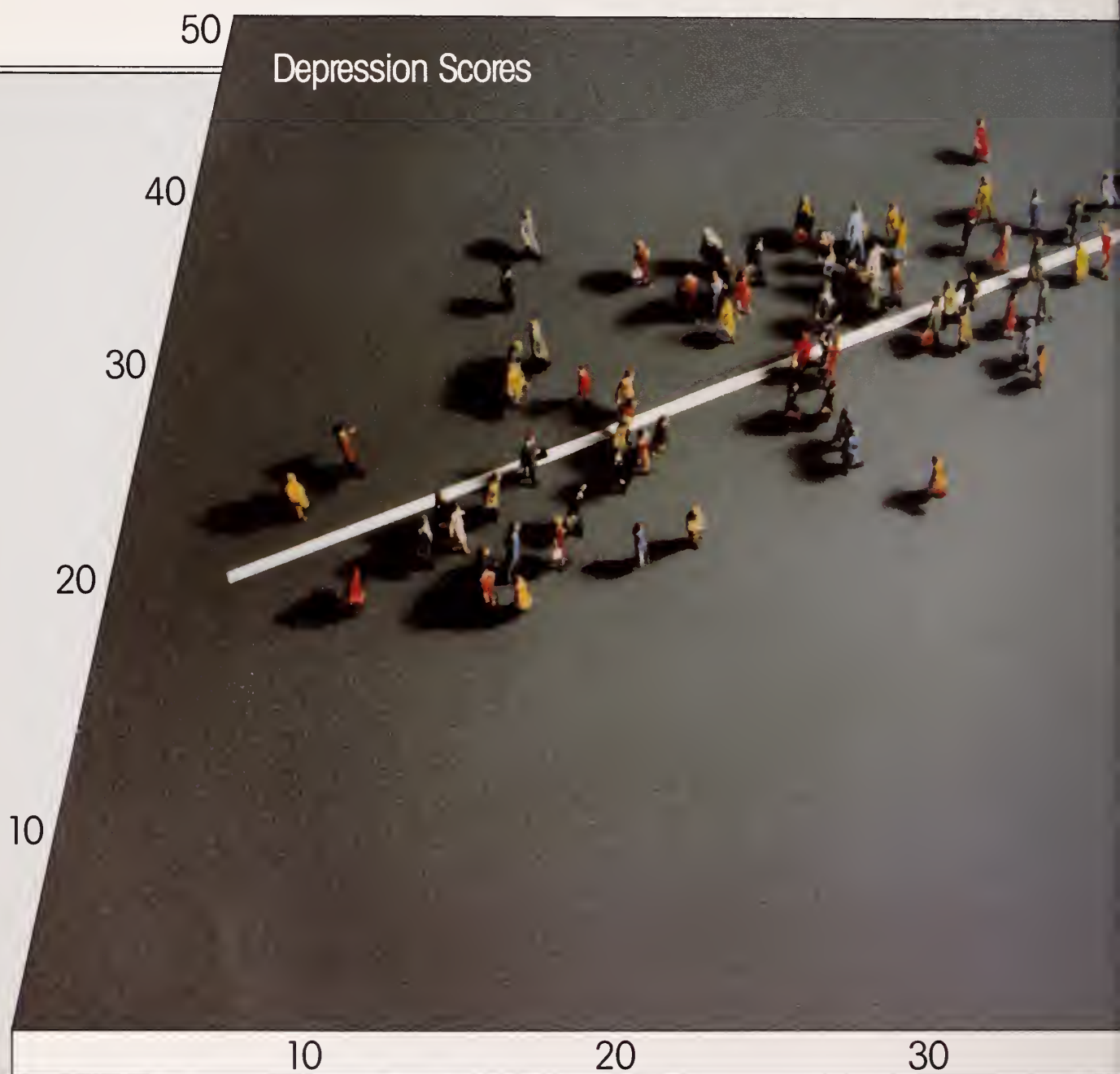
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"... toward the extension of medical knowledge, and to the advancement of medical science, to the elevation of the standard of medical education, and to the enactment and enforcement of just medical laws, to the promotion of friendly intercourse among the physicians and to guarding and fostering of their opinion in regard to the great problems of medicine, so that the profession shall become more honorable and capable within itself, and more useful to the public in the prevention and care of disease, and in the prolonging of and adding comfort to life."

—Preamble to the
*Constitution of the Mississippi
State Medical Association*

FOR THE 7 OF 10 NONPSYCHOTIC



Clear correlation between anxiety and depression³

The above graph illustrates a relationship between anxiety and depression, indicating that patients seldom present with anxiety or depression alone; more often they have both in varying degrees. Data based on a sampling of 100 outpatients (64 male; 36 female) seen at a general psychiatric clinic.

³Adapted from Clogharn, J. The anxiety-depression syndrome. *Psychosomatics* 11:438-441, Sept-Oct 1970.

DEPRESSED PATIENTS WHO ARE ALSO ANXIOUS^{1,2}

Most depressed patients are also anxious. . .

Some authors estimate that 70% of all nonpsychotic patients with symptoms of depression have concomitant symptoms of anxiety.^{1,2} One author found a distinct correlation between anxiety and depression scores in 100 nonpsychotic outpatients administered the Minnesota Multiphasic Personality Inventory in a general psychiatric clinic.³ As depression scores increased, so did anxiety scores. No attempt was made to select patients other than to exclude psychotics.

but not psychotic

The logic of treating both components of anxious depression is clear. Antipsychotics, like the phenothiazines, however, carry a well-documented risk of tardive dyskinesia.⁴ Because of this, an APA Task Force recently recommended the judicious use of phenothiazines in cases other than chronic psychosis or the use of alternative treatments.

A better way to give relief

Limbitrol combines the specific anxiolytic action of Librium® (chlordiazepoxide HCl/Roche)—a benzodiazepine with a long history of safe use—with the antidepressant action of amitriptyline, a tricyclic of established clinical efficacy. In comparison to phenothiazines, Limbitrol and its components have rarely been associated with tardive dyskinesia or other extrapyramidal side effects. And in terms of rapid response and patient compliance, Limbitrol appears to be superior to amitriptyline alone. Controlled multiclinic studies showed Limbitrol relieved more symptoms more rapidly than did amitriptyline.⁵ Despite a higher incidence of drowsiness, the dropout rate due to side effects was lower with Limbitrol. (See adverse reactions section in summary of product information on next page. As with any CNS-acting agent, patients should be cautioned about driving or using dangerous machines while on therapy with Limbitrol.)

References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, ed. Jarvik ME. New York, Appleton-Century-Crofts, 1977, p. 316. 2. Schatzberg AF, Cole JO: Benzodiazepines in depressive disorders. *Arch Gen Psychiatry* 35:1359-1365, 1978. 3. Claghorn J: The anxiety-depression syndrome. *Psychosomatics* 11:438-441, 1970. 4. The Task Force on Late Neurological Effects of Antipsychotic Drugs: Tardive dyskinesia, summary of a task force report of the American Psychiatric Association. *Am J Psychiatry* 137:1163-1172, 1980. 5. Feighner JP *et al*: A placebo-controlled multicenter trial of Limbitrol versus its components (amitriptyline and chlordiazepoxide) in the symptomatic treatment of depressive illness. *Psychopharmacology* 61:217-225, 1979.

Anxiety Scores

50

In moderate depression and anxiety

Limbitrol[®] IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Relief without a phenothiazine

Please see summary of product information on next page.

LIMBITROL® TABLETS Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated. Sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12.

In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects at both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12 5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50.

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JOURNAL of the MISSISSIPPI State Medical Association



February 1982, Volume XXIII, Number 2

125th Anniversary Year

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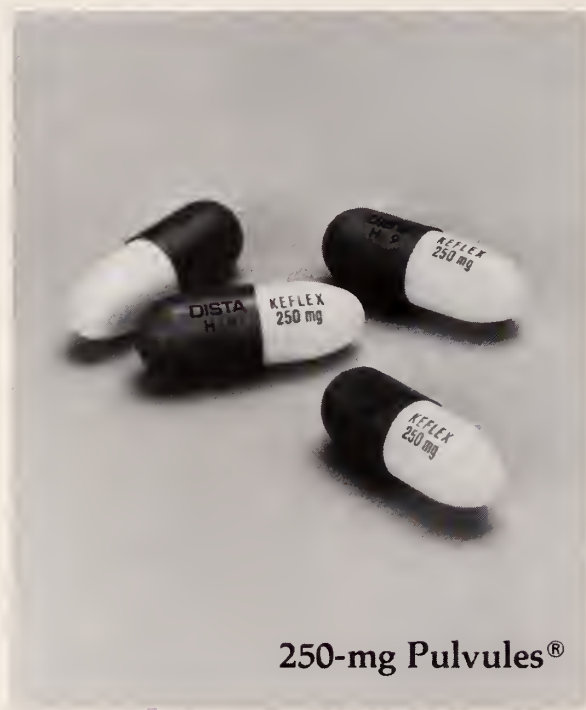
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Full range symptom-reliever for patients with air way congestion in the upper chest as well as the nose and throat.

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Phenylephrine Hydrochloride	25 mg
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Hyoscyamine Sulfate	0.19 mg
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Ru-Tuss Tablets act continuously for 10 to 12 hours

Ru-Tuss Tablets are an oral antihistaminic, nasal decongestant and anti-secretory preparation.

INDICATIONS AND USAGE Ru-Tuss Tablets provide relief of the symptoms resulting from irritation of sinus, nasal and upper respiratory tract tissues. Phenylephrine and phenylpropanolamine combine to exert a vasoconstrictive and decongestive action while chlorpheniramine maleate decreases the symptoms of watering eyes, post nasal drip and sneezing which may be associated with an allergic-like response. The belladonna alkaloids, hyoscyamine, atropine and scopolamine further augment the anti-secretory activity of Ru-Tuss Tablets

CONTRAINDICATIONS Hypersensitivity to antihistamines or sympathomimetics. Ru-Tuss Tablets are contraindicated in children under 12 years of age and in patients with glaucoma, bronchial asthma and women who are pregnant. Concomitant use of MAO inhibitors is contraindicated.

WARNINGS Ru-Tuss Tablets may cause drowsiness. Patients should be warned of the possible additive effects caused by taking antihistamines with alcohol, hypnotics, sedatives or tranquilizers.

PRECAUTIONS Ru-Tuss Tablets contain belladonna alkaloids, and must be administered with care to those patients with glaucoma, or urinary bladder neck obstruction. Caution should be exercised when Ru-Tuss Tablets are given to patients with hypertension, cardiac or peripheral vascular disease or hyperthyroidism. Patients should avoid driving a motor vehicle or operating dangerous machinery (See Warnings).

OVERDOSAGE Since the action of sustained release products may continue for as long as 12 hours, treatment of overdoses directed at reversing the effects of the drug and supporting the patient should be maintained for at least that length of time. Saline cathartics are useful for hastening evacuation of unreleased medication. In children and infants, antihistamine overdosage may produce convulsions and death.

ADVERSE REACTIONS Hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia may occur. Other adverse reactions to Ru-Tuss Tablets may be drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension, hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, dizziness and insomnia. Large overdoses may cause tachypnea, delirium, fever, stupor, coma and respiratory failure.

DOSAGE AND ADMINISTRATION Adults and children over 12 years of age, one tablet morning and evening. Not recommended for children under 12 years of age. Tablets are to be swallowed whole.

HOW SUPPLIED

Bottles of 100 Tablets

Bottles of 500 Tablets

Federal law prohibits dispensing without prescription.

NDC 0524-0058-01

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MANUFACTURED BY:

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Springfield Gardens, New York 11413

RU-TUSS[®]

Expectorant

DESCRIPTION

Each fluid ounce of Ru-Tuss Expectorant contains:

Codeine Phosphate	65.8 mg
(WARNING: MAY BE HABIT FORMING)	
Phenylephrine Hydrochloride	30 mg
Phenylpropanolamine Hydrochloride	20 mg
Pheniramine Maleate	20 mg
Pyrimamine Maleate	20 mg
Ammonium Chloride	200 mg
Alcohol	5%

Ru-Tuss Expectorant is an oral antitussive, antihistaminic, nasal decongestant and expectorant preparation.

INDICATIONS AND USAGE Ru-Tuss Expectorant is indicated for symptomatic relief of upper respiratory congestion associated with pharyngitis, tracheitis, bronchitis, and allergic rhinitis. Also, for the temporary relief of symptoms associated with hay fever, allergies, nasal congestion and cough due to the common cold.

CONTRAINDICATIONS Hypersensitivity to antihistamines. Concomitant use of an anti-hypertensive or antidepressant drug containing a monoamine oxidase inhibitor is contraindicated.

Ru-Tuss Expectorant is contraindicated in patients with glaucoma, bronchial asthma and in women who are pregnant.

WARNINGS Ru-Tuss Expectorant contains codeine phosphate, therefore, the patient should be warned of the potential that this drug may be habit forming. Ru-Tuss Expectorant may cause drowsiness. Patients should be warned of the possible additive effect caused by taking antihistamines with alcohol, hypnotics, sedatives and tranquilizers.

PRECAUTIONS Patients taking Ru-Tuss Expectorant should avoid driving a motor vehicle or operating dangerous machinery (See Warnings). Caution should be taken with patients having hypertension, diabetes, hyperthyroidism and cardiovascular disease.

Caution should also be used in patients with pulmonary, hepatic or renal insufficiency.

ADVERSE REACTIONS Ru-Tuss Expectorant may cause drowsiness, lassitude, giddiness, dryness of mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension, hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, and insomnia. Overdoses may cause restlessness, excitation, delirium, tremors, euphoria, metabolic acidosis, stupor, tachycardia and even convulsions.

DOSAGE AND ADMINISTRATION Adults: 1 or 2 teaspoonfuls, orally, every 4 hours, not to exceed 10 teaspoonfuls in any 24-hour period.

Children 6 to 12 years of age: $\frac{1}{2}$ the adult dose, not to exceed 6 teaspoonfuls in any 24-hour period. Children 2 to 6 years of age: $\frac{1}{2}$ teaspoonful every 4 hours, not to exceed 3 teaspoonfuls in any 24-hour period. Children under 2 years of age: Use as directed by a physician.

HOW SUPPLIED (16 fl. oz.)

Pint Bottles

Federal law prohibits dispensing without prescription.

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May 2-6, 1982

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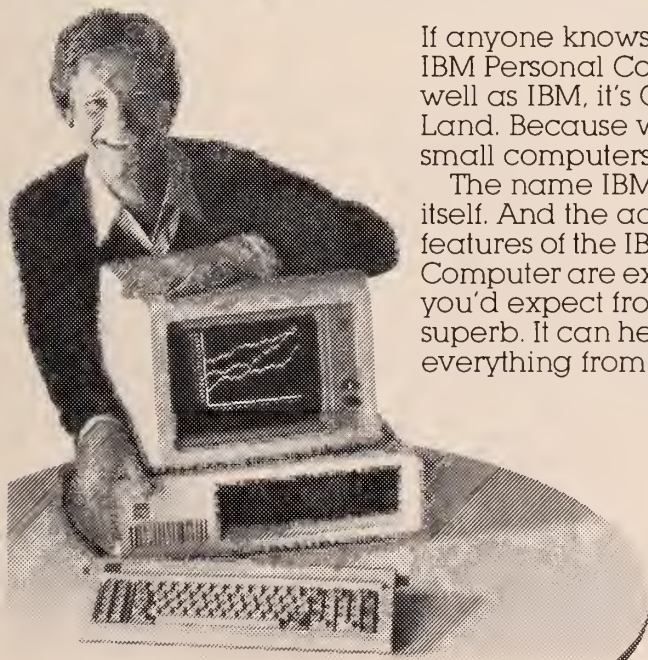
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As of January 1, 1982, a number of changes have been made in the Federal regulations governing IRA (Individual Retirement Account) and Keogh Tax-Deferred Retirement Savings Plans. The major changes that would be of primary interest to the medical profession are summarized below:

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Federal regulations require a substantial interest penalty for early withdrawal of funds from an IRA. Also, the Internal Revenue Service imposes a 10% penalty on the amount withdrawn and the amount withdrawn must be included in taxable income.

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NEWSLETTER

February 1982

Dear Doctor:

Medicare and Medicaid will apparently be targeted for the brunt of cuts in so called entitlement programs when Congress considers a 1983 budget later this year. One proposal calls for some \$5 billion in cuts by reducing payments to hospitals and physicians under Medicare, with recipients required to make up the difference. Federal Medicaid matching funds to the states would also be reduced, and deductibles and co-payments could be required.

The reductions would apparently reinforce the Reagan Administration's belief that one way to stem rising health care costs is to make patients more concerned about those costs as they reach into their pockets to pay health care bills.

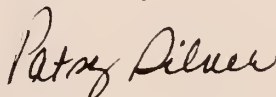
A bill to limit the FTC's jurisdiction over professions that are regulated by the states was introduced in the Senate. The bill, similar to an AMA draft bill, has bipartisan backing. Sen. James McClure (R-ID) said the measure "would end the suppression of self-regulation by preventing the FTC from initiating any more actions against the professions or their non-profit associations."

Calling for continued strong private-sector leadership in efforts to contain health care costs, President Daniel T. Cloud, M.D., urged the AMA to undertake new approaches to control the demand for care without sacrificing quality or availability. He also called on the AMA to promote a long-range national policy for testing all cost-containment proposals.

An AMA program to provide patients, through their physicians, with written information about prescription drugs will be in operation by mid-year. The first series of Patient Medication Instruction sheets (PMIs), designed to supplement the physician's oral instructions, will cover ten widely prescribed drugs. As many as 200 medications are expected to be included in the voluntary program.

Dr. Robert Bucklin, member of the team which has been conducting scientific tests on the Shroud of Turin, will address the Section on Pathology during MSMA's 114th Annual Session. The lecture is part of a widely varied scientific program scheduled for the annual session, which also includes House of Delegates meetings and many special events. Members are urged to make plans now to attend.

Sincerely,



Patsy Silver
Managing Editor

DRAMATIC NEW CLINICAL PROOF*

In the treatment of impetigo—

- **100% cure rate with Tegopen® (cloxacillin sodium)**
- **only a 60% cure rate with penicillin V-K**



As seen on admission



After one week of penicillin V-K therapy



Two weeks after initiation of TEGOPEN therapy

Treatment failure was judged to have occurred when lesions increased in size and/or number during the initial week of treatment with penicillin V-K. No treatment failures occurred with Tegopen.

*Data on file, Bristol Laboratories.

Brief Summary of Prescribing Information

TEGOPEN®
(cloxacillin sodium)
Capsules and Oral Solution

For complete information, consult Official Package Circular.

(12) 9/11/75

INDICATIONS:

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

RESULTS OF ORAL THERAPY revealed a high percentage of treatment failures with penicillin V potassium, but *no* failures with Tegopen.

		Given Tegopen® (cloxacillin sodium)	Given penicillin V-K
<i>Staphylococcus aureus</i>	(78 patients)	39	39
Returned to clinic at one week		29†	38†
Treatment failure at one week		0	18 (47.4%)
<i>Staphylococcus aureus</i> and <i>Streptococcus pyogenes</i>	(9 patients)	4	5
Returned to clinic at one week		4	5
Treatment failure at one week		0	2 (40%)
No initial bacterial growth	(14 patients)	9	5
All 14 healed, regardless of which antibiotic was administered.			
Beta-hemolytic <i>Streptococcus</i>	(1 patient)	0	1
TOTALS:	102 patients	52 patients	50 patients

†Eleven patients did not return for their one-week checkup. These were all called by telephone, and their families reported

the lesions had healed. One patient was dropped from the study early, because of adverse reaction to medication.

STUDY: DESCRIPTION/PROTOCOL

- 102 nonselected subjects, with initial bacteriology as follows: 77% *Staphylococcus aureus*, 9% mixed *Staphylococcus aureus* and *Streptococcus pyogenes*, and 1% beta-hemolytic *Streptococcus*.†
- All patients were given randomized therapy—Tegopen capsules or oral solution, or penicillin V-K tablets or oral solution, in recommended dosages according to body weight.

- All patients were evaluated after one week's therapy. If there was no improvement, therapy was switched to the other antibiotic. The "other antibiotic" proved to be Tegopen 100% of the time because no treatment failures had occurred with Tegopen.

- A final assessment of progress was made two weeks after initiation of Tegopen therapy.

†The remainder, to equal 100%, consisted of 14 patients (13%) who exhibited no initial bacterial growth. These 14 were all healed, whether given Tegopen or penicillin V-K

TEGOPEN®

(cloxacillin sodium)

-effective therapy for staph infections of the skin and skin structures

WARNING:

Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

PRECAUTIONS:

The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:

Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose

stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:

Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B. INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

SUPPLIED:

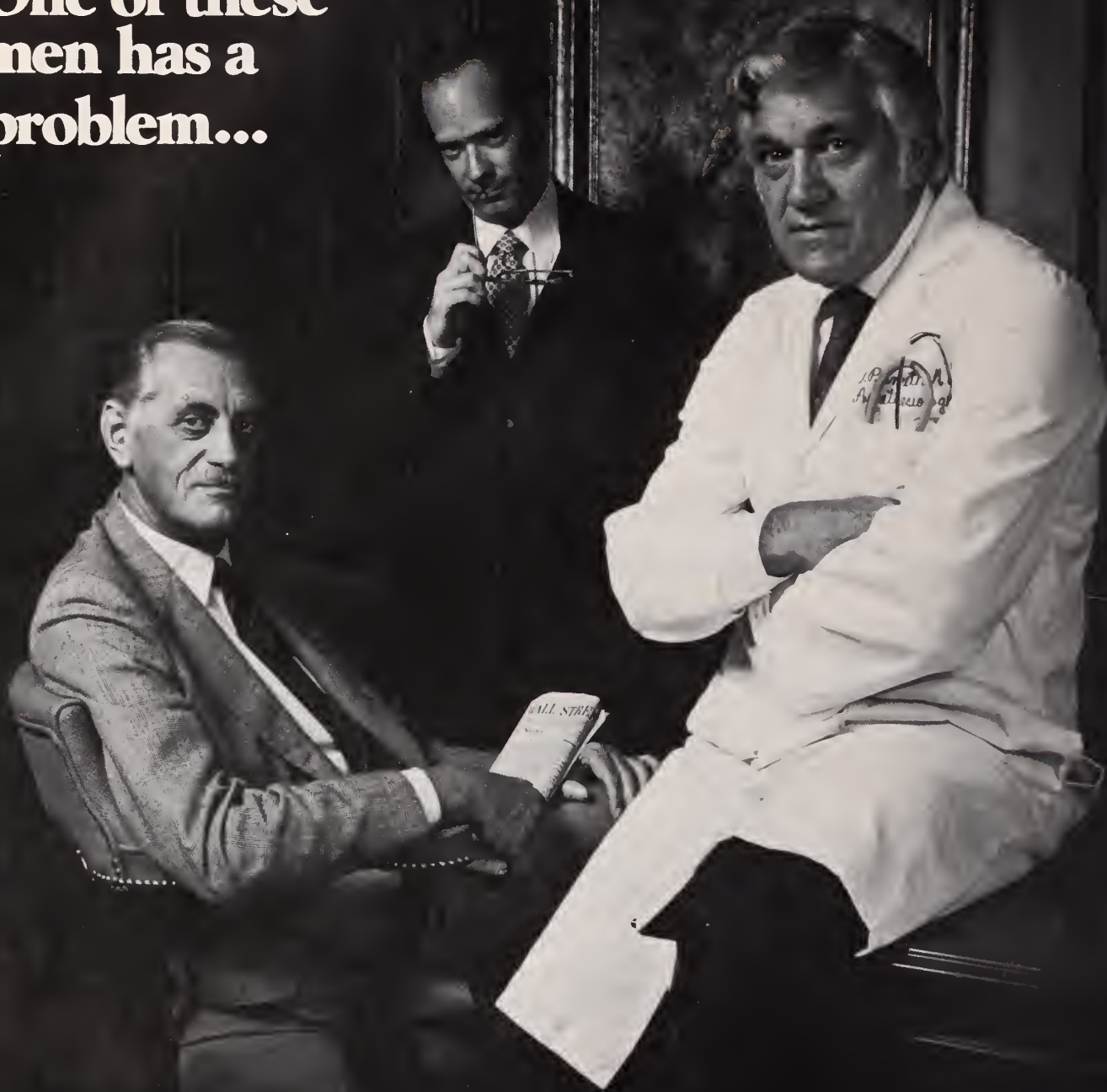
Capsules—250 mg. in bottles of 100. 500 mg. in bottles of 100.
Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

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**One of these
men has a
problem...**



and so do his family and colleagues.

There are special considerations in the treatment of professionals and executives who are impaired through dependency on drugs or alcohol: not because the patient or his addiction is different from others, but because of the strict sanctions imposed by the public and professional communities.

The A & D Center specializes in the treatment of the professional or executive who is chemically dependent. Treatment at the Center is designed to provide complete medical and counseling services, with care, dignity, and confidentiality for the patient. Family care and aftercare are emphasized, and specific plans are made for the re-entry process.

The A & D Center, located at the modern, 162-bed Doctors Hospital in Jackson, offers a 96-hour evaluation program, with the total inpatient treatment program extending for thirty days. For further information on the A & D Center, contact:



Doctors Hospital A & D Center
2969 University Drive
Jackson, Mississippi 39216
(601) 982-8321

DATELINE

Eckerd's To Refuse
Methaqualone Rx

Jackson, MS - Eckerd Drug Company has informed MSMA that its pharmacies will no longer dispense prescriptions for methaqualone, to draw greater public and professional attention to the growing abuse problem associated with the drug. Eckerd's will also support action to reclassify the drug from Schedule II to Schedule I. Regarding another drug, MSMA is supporting current Licensing Board efforts to seek legislation prohibiting the prescription of amphetamines for weight control.

Isolation Ordered
For TB Carrier

Tupelo, MS - A TB patient who has defied medical advice for almost two decades has been ordered into the custody of the State Board of Health by Alcorn County Chancery Judge Fred Wright. Officials say the man is responsible for giving tuberculosis to at least 19 people and is also believed to be connected with a 1976 outbreak of resistant TB. In that episode 30 people contracted the disease and two died. The man's documented recalcitrance resulted in the isolation order.

Americans Rate
Health Care

Washington, DC - Most Americans continue to be satisfied with the quality of their health care, according to a new study by the Health Insurance Association of America. Some 82% of persons surveyed are satisfied with their health care, a number which has remained consistent since 1977. Almost 70% believe health care costs could be reduced if people took better care of themselves, and 50% said they would be willing to pay higher premiums if insurance covered the cost of preventive care.

MD Finds Nurse
Role Exhausting

Chicago, IL - A physician concerned about the high turnover among intensive care nurses worked for one week as a nurse in the unit he usually supervises. He "discovered that he really had no concept of what a nurse's job was like," he told AM News, and he also found that nurses are more knowledgeable than he had thought. He believes the problems he faced -- a grueling workload and staff friction -- are largely endemic to the whole profession.

Ad Man Predicts
New Kind of MD

Chicago, IL - The day of the solo practitioner is on the way out, predicts a New York advertising executive and author of a book on professional advertising. Factors are increasing competition and the skyrocketing cost of opening a practice, he told AM News. He predicts physicians "will have to...market their services," and says the acceptance of advertising is greatest among the younger professionals -- the 14,000 new physicians entering practice each year.

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The basic idea of Thomas Yates & Co. hasn't changed. It's just grown. Good ideas usually do.

As we begin our fourth decade of service to the Mississippi State Medical Association, Thomas Yates & Co. has continued to upgrade coverages and to design well planned group insurance programs responsive to some very special needs of its members. Our aim is to steadily strengthen membership benefit programs through the introduction of new and improved coverages; to give members more protection for their money; to make insurance more adaptable and to back up the plans we offer with imagination and thorough service . . . That's the Thomas Yates idea — the simple but profound idea to offer its members the best possible group insurance plan.

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Compared to amoxicillin

Faster peak. Fewer problems.

... in infants and children

Cyclapen®-W (cyclacillin) produces twice the peak serum concentration* (15.6 mcg/ml versus 7.3 mcg/ml) in half the time (30 minutes versus 60 minutes).¹

Cyclapen®-W is just as effective in otitis media and streptococcal tonsillopharyngitis†.²

Cyclapen®-W produces a significantly lower incidence of the most common side effect, diarrhea.²

CYCLAPEN®-W
(cyclacillin) Tablets/Suspension

Rapid onset of action with fewer side effects.

*Rapidly excreted unchanged in urine.

Clinical efficacy may not always correlate with blood levels.

†Due to susceptible organisms.

1. Ginsburg CM, McCracken GH Jr, Zweighaft TC, Clahsen JC: Comparative pharmacokinetics of cyclacillin and amoxicillin in infants and children. *Antimicrob Ag Chemother*

19:1086-1088 (June) 1981.

2. Multicenter trials. Data to be published

See important information on page after next.

Compared to ampicillin

Faster peak. Fewer problems.

... in adults and children

Cyclapen®-W (cyclacillin) produces peak serum concentrations* almost four times higher and over one hour earlier.³

Cyclapen®-W is just as effective in otitis media, bronchitis, pneumonia, urinary tract infections and infections of skin and skin structures†.³

Cyclapen®-W produces a significantly lower incidence of diarrhea and skin rash.³

CYCLAPEN®-W
(cyclacillin) Tablets/Suspension

Rapid onset of action with fewer side effects.

*Rapidly excreted unchanged in urine.
Clinical efficacy may not always correlate with blood levels.

†Due to susceptible organisms.

3. Data on file. Wyeth Laboratories.
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See important information on adjoining page.

Wyeth Laboratories
Philadelphia, Pa 19101

Cyclapen®-W (cyclacillin)

Indications

Cyclacillin has less *in vitro* activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.

†depending on severity

How Supplied Tablets 250 mg and 500 mg in bottles of 100. Oral Suspension 125 mg and 250 mg per 5 ml in bottles to make 100 ml and 200 ml of Suspension.

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Philadelphia, Pa. 19101

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**When painful spasm
is the presenting
symptom...**

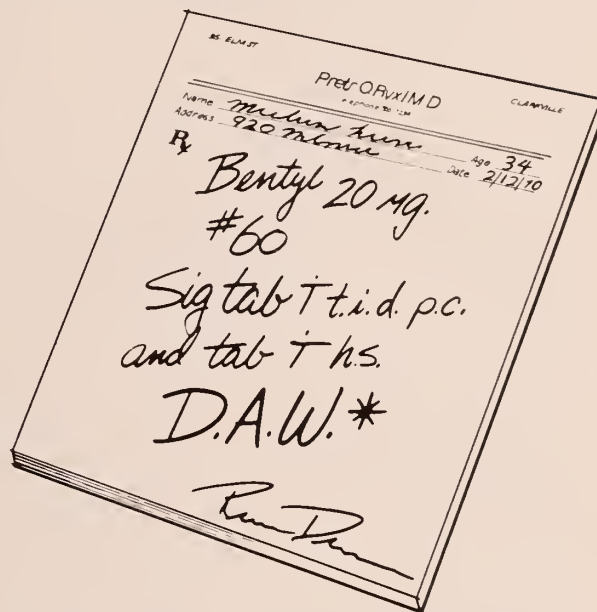


...in the functional bowel/irritable bowel syndrome*

be sure to specify

Bentyl®
(dicyclomine hydrochloride USP)

10 mg capsules, 20 mg tablets,
10 mg/5 ml syrup, 10 mg/ml injection



**D.A.W.-Dispense as written*

because:

- ⊕ The Bentyl molecule is a product of original Merrell research.
- ⊕ At Merrell Dow, Bentyl must go through 140 checkpoints/tests from its synthesis through the packaging of the final product.
- ⊕ Bentyl bioavailability of tablets, capsules, syrup and injectable is evidence of its prompt absorption.
- ⊕ Bentyl helps control abnormal gastrointestinal motor activity with minimal anticholinergic side effects. (See Warnings, Contraindications, Precautions, and Adverse Reactions on next page.)
- ⊕ The bioequivalence of the oral dosage forms permits a choice of tablet, capsules, or syrup that satisfies patient's dosage preferences.
- ⊕ Significant pharmacologic effect in the distal colon compared to placebo,¹ shows how Bentyl controls abnormal motor activity in the irritable colon patient.*

*This drug has been classified "probably" effective for this indication.

Merrell Dow

Reference:

1. Chowdhury AR and Lorber SH: Personal communication, 1980.

(See Product Information on the next page before prescribing Bentyl.)

Although the dose of Bentyl used to show pharmacologic effect was 50 mg, which is a higher single dose than that permitted in the labeling, the dose was considered justified, since the recommended daily dose of injectable Bentyl is 20 mg (2 ml) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg I.M. and, at that time, as a result of the sustained plasma levels from the 20 mg injections at 0 and 4 hours, might show an even higher plasma level than occurs after a single 50 mg dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

Bentyl[®]

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences-National Research Council and other information, FDA has classified the following indications as "probably" effective

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS

For use in the treatment of infant colic (syrup)

Final classification of the less-than-effective indications requires further investigation

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy) obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis), paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics, antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia, urinary hesitancy and retention, blurred vision and tachycardia, palpitations, mydriasis, cycloplegia, increased ocular tension, loss of taste, headache, nervousness, drowsiness, weakness, dizziness, insomnia, nausea, vomiting, impotence, suppression of lactation, constipation, bloated feeling, severe allergic reaction or drug idiosyncrasies including anaphylaxis, urticaria and other dermal manifestations, some degree of mental confusion and/or excitement, especially in elderly persons, and decreased sweating. With the injectable form there may be a temporary sensation of light-headedness and occasionally local irritation.

DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg capsule and syrup. **Adults:** 1 or 2 capsules or teaspoonfuls syrup three or four times daily. **Children:** 1 capsule or teaspoonful syrup three or four times daily. **Infants:** 1/2 teaspoonful syrup three or four times daily. (Dilute with equal volume of water.)

Bentyl 20 mg. **Adults:** 1 tablet three or four times daily.

Bentyl Injection. **Adults:** 2 ml (20 mg.) every four to six hours intramuscularly only.

NOT FOR INTRAVENOUS USE

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine[®] (bethanecol chloride USP) should be used.

Product Information as of July, 1980

Injectable dosage forms manufactured by

CONNAUGHT LABORATORIES, INC.

Swiftwater, Pennsylvania 18370 or

TAYLOR PHARMACAL COMPANY

Ocaturo, Illinois 62525 for

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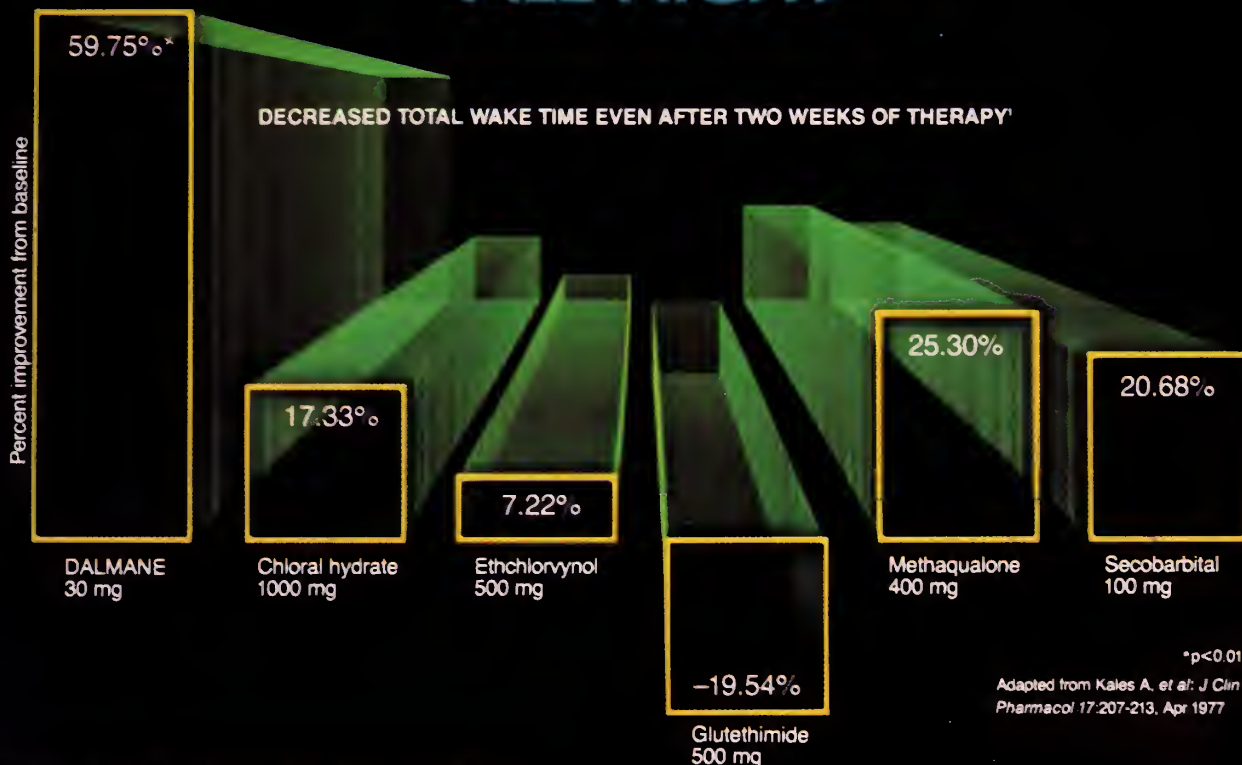
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GENERAL MOTORS PARTS DIVISION

Keep the great GM feeling with genuine GM parts.

EFFECTIVE ALL NIGHT



WITH AN UNSURPASSED RECORD OF EFFICACY AND SAFETY

The efficacy of Dalmane (flurazepam HCl/Roche) has been documented in 185 studies involving 9141 patients suffering from one or more of the three major forms of insomnia—difficulty falling asleep, staying asleep and sleeping long enough.²

Relative safety was demonstrated in a large study of 2542 hospitalized medical patients. Only 3.1% of these patients reported adverse reactions—predominantly unwanted residual drowsiness. None of the reactions were considered serious by attending physicians.³

FOR SLEEP WITHIN 17 MINUTES² AND NO WORSENING OF SLEEP ON DISCONTINUATION

Rapid sleep induction, within 17 minutes on average, sets the stage for insomnia relief. And, after discontinuation of Dalmane for periods ranging up to 14 nights, no worsening of sleep compared with baseline was observed.⁴

Should insomnia recur, the patient may require guidance in setting up a regular sleep program to help

provide the optimum environment for the onset of natural sleep. If hypnotic therapy is required, it should be given for the shortest time at the lowest effective dose to achieve the desired goal.

Consider other medications the patient may be taking (including alcoholic beverages) and be aware of possible drug interactions. Please note that patients should be treated for underlying physical or psychological factors before therapy with a sleep medication is undertaken.

DALMANE[®]
flurazepam HCl/Roche
THE STANDARD OF HYPNOTIC EFFICACY
FROM THE LEADER IN SLEEP RESEARCH



Please see reverse side for a summary of product information.



SLEEP-SPECIFIC **DALMANE**® flurazepam HCl/Roche

One 15-mg capsule h.s.—recommended initial dosage for elderly or debilitated patients.
One 30-mg capsule h.s.—usual adult dosage
(15 mg may suffice in some patients)

THE STANDARD FOR HYPNOTIC EFFICACY WITH IMPORTANT ADDED BENEFITS

- Well tolerated¹
- No chemical interference with many commonly ordered laboratory tests, including triglycerides, uric acid, glucose, SGOT, alkaline phosphatase and total protein^{2,6} (See adverse reactions section of complete product information.)
- Compatible with chronic warfarin therapy; no unacceptable fluctuation in prothrombin time reported^{7,8}

UNLIKE NONSPECIFIC MEDICATIONS USED FOR SLEEP

Tricyclic antidepressants

- which are *not* sleep specific,⁹ yet are sometimes used in nondepressed patients for sleep
- which can cause transient insomnia in the elderly¹⁰
- which can require careful monitoring in cardiovascular patients¹⁰
- which have strong anticholinergic effects¹⁰

Antihistamines

- which are *not* reliable sleep-inducing agents¹¹
- which may produce stimulation instead¹¹
- which have anticholinergic effects¹¹

Major tranquilizers

- whose side effects may be troublesome for nonpsychotic patients¹²
- where tolerance for sedation appears rapidly¹²

Dalmane does not cause significant worsening of sleep beyond baseline levels upon discontinuation.⁴

References: 1. Kales A, et al. *J Clin Pharmacol* 17:207-213, Apr 1977. 2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ. 3. Greenblatt DJ, Allen MD, Shader RI. *Clin Pharmacol Ther* 21:355-361, Mar 1977. 4. Kales A, et al. *Clin Pharmacol Ther* 18:356-363, Sep 1975. 5. Moore JD, Weissman L. *J Clin Pharmacol* 16:241-244, May-Jun 1976. 6. Spiegel HE. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ. 7. Robinson DS, Amidon EL. Interaction of benzodiazepines with warfarin in man. In *The Benzodiazepines*, edited by Garattini S, Mussini E, Randall LO. New York: Raven Press, 1973, pp 641-646. 8. Warfarin Study. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ. 9. Baldessarini RJ. Drugs and the treatment of psychiatric disorders, chap 19. In Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6. New York: Macmillan Publishing Co. Inc., 1980, pp 391-447. 10. Cole JO, Davis JM. Antidepressant drugs, chap 31.2, in *Comprehensive Textbook of Psychiatry II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2. Baltimore: The Williams & Wilkins Company, vol 2, 1976, pp 1941-1956. 11. Douglas WW. Histamine and 5-hydroxytryptamine (serotonin) and their antagonists, chap 26, in Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6. New York: Macmillan Publishing Co. Inc., 1980, pp 609-646. 12. Davis JM, Cole JO. Antipsychotic drugs, chap 31.1, in *Comprehensive Textbook of Psychiatry II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2. Baltimore: The Williams & Wilkins Company, vol 2, 1976, pp 1921-1940.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age.

Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect.

Adults: 30 mg usual dosage; 15 mg may suffice in some patients. **Elderly or debilitated patients:** 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



ROCHE PRODUCTS INC
Manati, Puerto Rico 00701

ORIGINAL PAPERS

Brace Treatment of Scoliosis

WILLIAM R. STEWART, M.D. and J. PATRICK BARRETT, M.D.

Jackson, Mississippi

SCOLIOSIS IS BEING IDENTIFIED more often in younger patients. This is due to heightened public awareness and the use of school screening programs in some areas. Scoliosis is an abnormal lateral curvature of the spine. The most common form is idiopathic scoliosis seen in adolescence. Currently, conservative management of scoliosis is indicated in mild to moderate curves in juvenile or in adolescent individuals.

Conservative management includes observation of mild curves or bracing of more severe or progressive curves. Brace treatment of scoliosis took a giant step forward in the twentieth century with the development of the Milwaukee brace (see Figures 1A and 1B). Originally, this was devised by Blount and Schmidt as a support device which was to be used as a postoperative brace.¹ However, over the course of years various modifications extended its indications. It has probably been the most widely used brace in the treatment of scoliosis. Long-term studies of its effectiveness have proven that it can stabilize progression of mild to moderate scoliotic curves.^{2, 3}

However, since most scoliosis requiring treatment occurs in idiopathic adolescent form, certain problems arise in brace treatment. The Milwaukee brace, and other types, must be fitted carefully to the individual wearer and have to be carefully adjusted and maintained during use. A brace of any type must be worn full time to be effective, and once brace treatment is selected, it should be used until the patient reaches skeletal maturity. Since adolescence is a period of unusually heavy peer pressure and social consciousness, adequate compliance with a brace treatment program becomes a problem in some adolescents.^{4, 5}

In the past decade several alternative brace types have been developed for use in specific curve types. One of these type braces, which is coming into more wide use, is the custom molded, total contact, lightweight plastic body jacket^{6, 7, 8, 9} (see Figures 2A and 2B). It is generally not applicable for all curves and cannot be used to control curves with an apex above T-6-7. It must, like the Milwaukee brace, be custom formed to the individual patient, and must be worn full time until skeletal maturity. Because it has no visible uprights, it is more readily concealed by clothing. If it is as effective as the Milwaukee brace, its less conspicuous appearance could prove to be an advantage in patient compliance with a brace treatment program.

We present a comparison of two similar groups of patients with adolescent idiopathic scoliosis treated with either the Milwaukee brace or a low profile plastic body jacket.

Materials and Methods

Sixty children being treated for idiopathic adolescent scoliosis through this office between 1976 and 1980 were reviewed. These 60 patients were consecutive patients undergoing brace treatment. They had complete office records available, and to date all have been discontinued from brace treatment. Twenty-one had been treated with a Milwaukee brace, and 39 had been treated with a plastic body jacket. Patients who have a curve pattern with an apex higher than T-6-7 were excluded from the review. The cases were studied with reference to the type of curve (thoracic, thoracolumbar, lumbar, or double major), the original severity of the curve, the degree of the curve during the best period of brace treatment, and the final curve after completion of brace wear. Also noted were the number of progressions of curves which occurred during brace treatment, and

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Figure 1A. Milwaukee brace (front view).



Figure 1B. Milwaukee brace (back view).

those cases in which there was a problem with non-compliance of brace wear. Difficulties with brace fitting, the number of new braces required during the treatment period, and the number of recorded visits to the brace manufacturer for new fittings or repair, were compared for the two groups. All the braces were manufactured by the same brace shop, and were fitted and fabricated under standard conditions.

The average curves in the Milwaukee brace and the Boston brace group are presented in Table 1. It was noted that both brace types produced improvement in the measureable curve while the brace was being worn, but after completion of brace wear the curves returned toward the pre-brace status. A slightly increased residual improvement in all curve patterns was noted in the group treated with the body jackets.

Six of the 21 Milwaukee brace wearers had progression of the severity of their curve during the period of treatment. Two of the 39 body jacket wearers had progression. It is not clear whether this represents an advantage in control of the curve by the body jacket, increased compliance in wearing the

jacket, or both. Non-compliance of brace use was a more serious problem in the Milwaukee brace group. Six of the 21 patients rejected brace wear at some point in the Milwaukee brace group, compared to four of the 39 body jacket wearers.

Six of the 21 Milwaukee brace users had significant enough problems with the fit and tolerance of the brace to require major modifications or refabrication of the brace. Four of the 39 body jacket users experienced such difficulties. The most common complaint in the body jacket category was some skin irritation underneath the jacket.

Four of the Milwaukee brace patients had to have a new brace during the course of treatment, and seven of the Boston brace group required new jackets because of growth. The Milwaukee brace patients required an average of 6.6 visits to the brace shop for major repair, readjustments, or new fittings during the treatment period, as opposed to 4.4 average brace shop visits of the body jacket group.

Four of the Milwaukee brace patients ultimately came to surgical management of their scoliosis because of progression of the curve, either during the

TABLE I
AVERAGE CURVES

<i>Milwaukee</i>		<i>Body Jacket</i>	
(Initial)		(Initial)	
Thoracic	33°	Thoracic	27°
Lumbar	23°	Lumbar	22°
T-L	31°	T-L	21°
(Braced)		(Braced)	
Thoracic	29°	Thoracic	19°
Lumbar	18°	Lumbar	15°
T-L	27°	T-L	12°
(Final)		(Final)	
Thoracic	32°	Thoracic	22°
Lumbar	24°	Lumbar	18°
T-L	29°	T-L	14°

treatment period or after the brace was discontinued. Two of the patients in the Boston brace group ultimately have required surgical fusions. This may reflect multiple factors, including the slightly less severe curve measurements in the most recently treated body jacket patients, many of whom were detected through school screening programs.



Figure 2A. Plastic body jacket (front view).



Figure 2B. Plastic body jacket (back view).

Discussion

The Milwaukee brace represented a landmark development in the conservative management of scoliosis. It has been a tried and proven method of treatment for mild to moderate idiopathic scoliosis, and stands alone as a means of brace stabilization of scoliosis curves with apex above T-6-7. Nevertheless, newer developments in brace types and techniques have made available other options for treatment of idiopathic scoliosis with an apex below the T-6-7 level.

The Milwaukee brace does require expert fitting and maintenance and, as any supportive device, requires total patient cooperation in its use. Psychosocial problems during adolescence may be heightened by having to wear a brace which is obvious to a youngster's peers. This can lead to reluctance to use the brace at best or psychological problems at worst.

The availability of a less obvious and apparently equally effective brace may present advantages in patient acceptance of brace treatment. The molded plastic underarm body jacket that is described here appears to be comparably effective for management

of selected cases of idiopathic adolescent scoliosis, in comparison to the conventional Milwaukee brace. It does require careful fitting and must be made with special techniques, which may not be widely available in some areas. This, however, seems to be offset by its ease of maintenance and slightly lower incidence of readjustment and refitting.

Summary

A review of 60 cases of adolescent idiopathic scoliosis with adequate treatment and follow-up to the completion of brace treatment is presented. The molded low profile plastic body jacket appears to be comparably as effective in a brace treatment program as a Milwaukee brace. The Milwaukee brace can be used for treatment of curves in the cervicothoracic or high thoracic region. The plastic body jacket must be restricted to curve patterns with apexes below T-6-7, in the authors' experience and in keeping with current literature. The availability of a less conspicuous brace format may, in some instances, have advantages in patient compliance to brace wear. ★★★

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Bibliography

1. Blount, W. P., Schmidt, A. C., Keever, D. D. and Leonard, E. T.: The Milwaukee brace in the operative treatment of scoliosis. *J. Bone Joint Surg.* 40A:511, 1958.
2. Blount, W. P. and Mellencamp, D.: Long-term results of idiopathic scoliosis treated with the Milwaukee brace. *Clin. Orthop.* 126:47, 1977.
3. Edmonson, A. S. and Morris, J. T.: Follow-up study of Milwaukee brace treatment in patients with idiopathic scoliosis. *Clin. Orthop.* 126:58, 1977.
4. Myers, B. A., Friedman, S. B. and Weiner, I. B.: Coping with a chronic disability: Psychosocial observations of girls with scoliosis treated with a Milwaukee brace. *Am. J. Dis. Child.* 120:175, 1970.
5. Neff, J.: Feminine identity concerns of girls undergoing correction of scoliosis. *Maternal Child Nursing J.* 1:9, 1972.
6. Bunnell, W. P. and MacEwen, G. D.: Use of orthoplast jacket in the non-operative treatment of scoliosis. Presented at Annual Meeting of Scoliosis Research Society, Louisville, Kentucky, September, 1975. *J. Bone Joint Surg.* 58A:156, 1976.
7. Bunnell, W. P., MacEwen, G. D. and Jayakumar, S.: The Use of plastic jackets in the non-operative treatment of idiopathic scoliosis. *J. Bone Joint Surg.* 62-A(No. 1):31, 1980.
8. Levine, D.: Results of underarm brace treatment of idiopathic scoliosis. Paper presented at American Academy of Orthopaedic Surgeons, Course on Scoliosis, Indianapolis, Indiana, May 4, 1976.
9. Murphy, J.: The Lexan jacket in the conservative treatment of scoliosis — a comparison of results obtained with the Milwaukee brace. Presented at the Annual Meeting of the Western Orthopaedic Association, Honolulu, Hawaii, October, 1974. *J. Bone Joint Surg.* 57A:136, 1975.

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A Birth to Death Preventive Medicine—Periodic Health Screening Protocol

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MANY PREVENTIVE MEDICINE measures, such as immunizations, are well standardized and universally accepted. This is not true of many periodic health screening procedures. In recent years, the annual physical examination itself has come under attack. It is felt to be ineffective in changing the outcome of many diseases and to be a wasteful use of medical resources.⁸ This applies to many other screening procedures as well. The question arises, then — what procedures should be done and how often? To help answer this question specific criteria have been developed for periodic health screening (see Table 1).⁸

Periodic health screening is no longer a procedure that physicians may choose to do or not to do. The Washington State Supreme Court ruled in 1974, in the case of a woman who suffered permanent visual impairment from glaucoma, that physicians could be held accountable for not doing certain screening procedures, such as tonometry.¹⁶ The purpose of this article is to present a birth-to-death preventive medicine/periodic health screening protocol in a format for office use.

Periodic Health Screening

We recommend specific periodic health screening for the following:

1. Abnormalities of growth and development
2. Hearing loss
3. Visual problems (acuity, strabismus, glaucoma)
4. Scoliosis
5. Cardiovascular risk factors (hypertension, hyperlipidemia, diabetes, sedentary life style, smoking and obesity)
6. Cancer (cervical, breast, colorectal, testicular)
7. Anemia
8. Renal disease

TABLE 1
SCREENING CRITERIA

-
- | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ol style="list-style-type: none">1. The disease must have a significant effect on quality or quantity of life.2. Acceptable methods of treatment must be available.3. The disease must have an asymptomatic period during which detection and treatment significantly reduce morbidity and/or mortality.4. Treatment in the asymptomatic phase must yield a therapeutic result superior to that obtained by delaying treatment until symptoms appear.5. Tests must be available at reasonable cost to detect the condition in the asymptomatic period.6. The incidence of the condition must be sufficient to justify the cost of screening. |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
-
9. Sexually transmitted diseases (syphilis and gonorrhea)
 10. Menopause
 11. Alcohol and drug abuse
 12. Various diseases and lesions of the chest other than lung cancer
 13. Various conduction and rate abnormalities of the heart
 14. Sickle cell trait in blacks
 15. Rubella immunity in females
 16. Phenylketonuria in neonates
 17. Hypothyroidism in neonates

Screening for these conditions can be done by use of the following procedures:

Complete physical examination. Some recommend that a complete physical examination should be done only at the first visit.²² The days of the recommended annual physical examination do appear to be over. A compromise between the two extremes seems appropriate. Young children and elderly people need physical examinations more often than most people because they are more susceptible to disease. Examinations are more important in middle aged individuals than young adults because of the higher incidence of heart disease and cancer.^{24, 26} A schedule for physical examinations in which the frequency of the examination depends

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on expected returns seems logical.^{1, 5, 24, 26} We recommend complete physical examinations at birth, one, two and six months and at 1, 1½, 2, 3 and 5 years. Thereafter, we recommend complete physical examinations every five years until age 25, and every four years until age 40, then every three years until age 53, then every other year until age 65, and then annually after that. Each physical should be tailored to the person's age, especially infants and young children who are developing rapidly. In general, the content of the physical examination for neonates, children, and adults is well defined. However, we will mention a few specific points in this article.

Complete history. A complete history is recommended on the initial visit only^{11, 22} and brought up to date on subsequent visits.²⁶ Menstrual history should be taken for the first time shortly after puberty⁵ and at each subsequent visit for a physical examination.²⁶

Growth screening. Patients should be weighed at birth and at each visit for a physical examination, as well as at each visit in between. The length of infants should be measured at birth and at each visit for physical examinations and/or immunizations. Older children should have their heights measured at each visit for a physical examination. We recommend that the height of adults be measured at 20 and 29 years of age as well as at age 55 and then every five years beginning at age 65. We recommend that head circumferences be measured at birth and at each visit for a physical examination and/or immunization to at least two years of age. Appropriate graphs for plotting length/height, weight and head circumference are available from a variety of sources.

Developmental screening. Developmental screening of infants and older children is recommended at each visit for a physical examination and/or immunization. An appropriate developmental screen should spot check physical, sensory/motor, intelligence and social development. More extensive screening should be done if the spot screening shows consistent abnormalities.

Blood pressure. Hypertension under the age of 10 is rare; however, it does become more common by adolescence.¹² Few, if any, would argue that a blood pressure check is appropriate between the ages of 10 and 15.^{1, 5, 12, 26} Whether it is warranted in younger children is controversial. Some recommend that blood pressure be checked in children beginning as young as 4 years of age.^{5, 26} whereas others do not. At any rate, if checked, the blood pressure cuff should be 20% wider than the diameter of the limb.¹⁸ Although no one disagrees that adults should have

their blood pressures checked regularly because the degree of target organ damage is proportional to the length of time the hypertension has been present, recommendations for when this should be done vary from every visit to the doctor for whatever reason,²⁴ to every two years,^{8, 21, 26} to each visit for a physical examination,²² which may be as far apart as every four to five years in some age ranges. We feel that blood pressure should be checked at each visit for a physical examination and during each visit in between, beginning at 5 years of age.

Scoliosis. Because scoliosis is more readily treatable in the young, scoliosis screening is important early in childhood. Screening should be done prior to school age and repeated again at age 10.¹² Others recommend an additional screen at age 15.⁵ We recommend scoliosis screening at 3, 5, 10 and 15 years of age.

Pap smear. Although agreement exists universally that cancer of the cervix is a slowly growing neoplasm, controversy still exists about how often a Pap smear should be done. Agreement does exist that the first one should be done when the patient becomes sexually active or 20 years of age, and repeated in one year. The American Cancer Society has recently recommended that a Pap smear be done every three years, after the initial two are negative, until age 65.¹⁵ The British National Health Service recommends one every five years to age 70.² The American College of Obstetricians and Gynecologists recommends annual Pap smears.²⁵ A reasonable compromise would seem to be to do the first at age 20 if the patient is not sexually active before this age, and to repeat it in one year. If both are negative, the test should be done thereafter every two years^{10, 21} until age 65.

Pelvic examinations. The American Cancer Society recommends a pelvic examination every three years from age 20 to 40 years and then annually after age 40.¹⁵ A reasonable alternative is every two years (when we recommend the Pap smear) until age 40, then annually.

Breast examination. The American Cancer Society recommends a breast examination every three years between the ages of 20 and 40 years and annually over age 40.¹⁵ Others recommend a breast check every one to two years to age 50, then annually after that.^{21, 26} A reasonable approach is to do one every two years at the time of the Pap and pelvic examination until age 50, then annually.¹¹

Testicular examination. The testicular examination should be part of every male physical examination.

Mammography. Mammography is the only test

that can detect a breast cancer before it becomes large enough to be felt on physical examination. It is, therefore, a valuable screening tool. However, it is somewhat expensive and does expose the breasts to radiation. The American Cancer Society recommends a mammography baseline between the ages of 35 and 40 years and then annually after age 50.¹⁵ Others feel that past age 50, every two years is not unreasonable.²¹ We feel that a baseline test should be done between the ages of 35-40 years and repeated every other year beginning at age 50.

Hearing. Periodic hearing examinations, beginning with the startle reflex at birth and progressing to audiometry for older children and adults, are generally accepted procedures. It would seem that the very young and the elderly should be screened more often than those in between. Hearing screens are recommended at birth and at regular intervals during childhood.^{1, 5, 12, 23, 26} In general, hearing tests have been recommended every five years for adults until age 65^{1, 21} and then every two years after that.¹ Hearing screening during the middle years of life, other than gross hearing tests during the physical examination, seems unwarranted in the absence of complaints and physical findings of decreased hearing. We recommend hearing screening (startle reflex) at one and two months of age, and audiograms at ages 5, 10, 15 and 20 years and at every other physical examination beyond age 40. We recommend gross hearing screening during physical examinations at 1, 1½, 2 and 3 years and with each physical examination after that.

Visual acuity. Screening for visual acuity is recommended initially as part of the preschool examination^{1, 5, 12, 26} and at regular intervals during childhood.^{1, 5} Adult screening has been recommended every five years to age 65, then every two years after that.¹ Vision testing other than gross testing during physical examinations during the middle years of life seems unwarranted in the absence of complaints about reading or other visual difficulty. We recommend vision testing at ages 5, 10, 15 and 20 years and with every other physical examination after age 40. Gross visual acuity testing may be done as part of each physical examination if desired.

Strabismus. Strabismus screening may be done by the Hirshberg test, in which a penlight is held about 13 inches from the patient's face and the corneal light reflex noted. The reflex should appear on identical areas of both cornea. The cover test may also be used. In this test one eye is covered and the patient is asked to focus on an object about one meter from the face. When the cover is suddenly removed, the uncovered eye should remain fixed. The test is repeat-

ed with the other eye covered. Consistent movement of one of the eyes, when the other is uncovered is a positive test. In reality, both the Hirshberg and cover test should be used.⁵ Strabismus screening is recommended for children only, beginning at 18 months of age and repeated at each scheduled visit for a physical examination until at least 6 years of age.^{5, 12} We recommend a strabismus screening at 1½, 2, 3 and 5 years of age.

Tonometry. Tonometry is the most widely used screening test for glaucoma. Tonometry coupled with fundoscopy, should be done every two to five years past age 40.^{11, 21, 22} We recommend that tonometry be done at each visit for a physical examination after age 40. Patients with abnormally high readings (greater than 21 mm Hg.) or pathological cupping should be referred to an ophthalmologist for further evaluation.

Proctosigmoidoscopy. Although it was once felt that 70% of all colorectal cancers occurred within the full range of the rigid proctosigmoidoscope, this estimate has recently been changed to 60%.⁷ Despite this, proctosigmoidoscopy would still seem to be a worthwhile screening procedure. The American Cancer Society recommends proctosigmoidoscopy every three to five years following two negative examinations one year apart at age 50.¹⁵ Others recommend only one examination at age 56 because this is the age of peak incidence of colorectal cancer.⁹ Others do not recommend it at all.⁷ A reasonable compromise would seem to be to do the procedure periodically for an age range on either side of 56. We recommend proctosigmoidoscopy every two to three years between the ages of 50 and 65. A digital rectal examination should be part of every adult physical examination.

Stool for occult blood. The hemoccult test is an excellent screen for colorectal cancer. Ideally, the patient should be on a no red meat diet (fish and fowl acceptable) while the specimens are being collected. A high fiber diet is also helpful in that it is more apt to cause bleeding from a colon lesion than a regular diet. One approach is to screen the population without regard to diet and repeat the positive hemoccult tests on a no red meat, high fiber diet. The major concern with the hemoccult test is the high rate of false negatives, which may be as high as 22%.²⁸ Therefore, hemoccult testing and proctosigmoidoscopy, along with digital rectal examination, should complement each other.²⁴ The American Cancer Society recommends a hemoccult test every year after age 50.¹⁵ Others feel that because of the simplicity of the test, it should begin earlier.⁹ We recommend an annual hemoccult test beginning at age 40.

Hematocrit. Recommendations for anemia screening in adults range from every two years²⁶ to every five years¹ for both male and female. Since women are more prone to develop anemia due to menstruation during the childbearing years, it would seem reasonable to screen them more often than men during this period of life. Anemia screening should initially be done at birth, and again between the ages of 6-18 months^{5, 26} especially in high risk infants (breast-fed more than the first six months of life, low neonatal hematocrits). Anemia screening as part of the preschool examination and again at ages 10 and 15 also seems reasonable. We recommend this schedule.

Blood glucose. Recommendations for diabetes screening is somewhat controversial because solid evidence is lacking that detection in the asymptomatic phase alters the long-term prognosis.⁹ Others feel that because the test is inexpensive and because of the large percentage of the population that has or will get diabetes, a screen should be done every five years until age 65, then every two years.¹ Others feel that a urinalysis every five years is adequate.²¹ Because juvenile onset diabetes occurs with an acute onset, screening is not recommended until adulthood or the late teens.^{1, 5} We recommend a fasting blood sugar beginning at age 15 with each visit for a physical examination until age 65, and at every other visit for a physical examination past age 65.

Creatinine. Serum creatinine is recommended as a screen for renal disease in adulthood at progressively decreasing intervals with advancing age, beginning every three to five years in young adulthood and progressing to annually after age 50 to 60.²⁴ Others feel that a BUN on the initial visit followed by a repeat BUN at age 45 and then annually after age 50 is appropriate.²² Still others feel that a urine analysis every five years is adequate.²¹ Some feel that screening for chronic renal disease is not indicated at all because of lack of treatment of end-stage disease except dialysis or transplantation.¹⁰ We recommend a serum creatinine beginning at age 20 with each visit for a physical examination until age 65, then with every other visit.

Urine analysis. Urine analysis is considered by many to be a useful screen for diabetes, urinary tract infection and the presence of bladder or kidney tumors in adults. Some feel that screening for asymptomatic bacteriuria is unwarranted because of lack of evidence that screening results in decreased morbidity and mortality.^{1, 5, 12} Others disagree.^{20, 23} Some feel that a urine analysis for screening asymptomatic adults for bacteriuria is also unwarranted because of the controversy associated

with treatment of such finding.^{2, 8} Some do not recommend it as a screening process in adults at all,^{1, 10, 22} while others recommend it on a regular schedule or on a progressively increasing incidence with age.^{21, 23, 24, 26} We recommend a urine analysis, beginning at age 5, with each physical examination until age 65, and then with every other physical examination. A urine culture may be done in female children at age 5 if desired.²⁰

Sickle Cell trait. Screening for sickle cell trait would seem warranted on a high-risk population (blacks) for the purpose of genetic counseling. The exact age is not crucial, but should be prior to the childbearing age.⁵ We recommend a sickle cell trait check at age 10.

Rubella titer. The prevalence of women in the childbearing age not immune to rubella is about 15%. Considering the catastrophic results that can occur from contacting rubella during pregnancy, rubella immunity would seem to be a desirable screening process. The most logical time for screening is just before childbearing age,⁵ although some recommend it in the later teenage years.¹ It should be remembered that pregnancy is not recommended for three months following immunization. We recommend a screen for rubella immunity at age 10.

Serum lipids. Blood cholesterol levels are clearly associated with risk of myocardial infarction. High serum triglycerides are not as strong a risk factor for heart disease as cholesterol.^{3, 27} They are, however, correlated with accelerated peripheral atherosclerosis,²⁷ so it is probably justifiable to screen for them. Screening for serum cholesterol is recommended every four to five years^{8, 21} beginning in the late teens.¹ It is not clear when, if at all, the beneficial affects of controlling serum lipids end. We recommend screening for cholesterol and triglycerides beginning at age 20 with each physical examination to age 53, then with every other physical examination to age 65. We do not recommend routine screening for serum lipid abnormalities beyond age 65.

Serological test for syphilis (VDRL, RPR). Seventy-five percent of undetected cases of syphilis will eventually develop irreversible tertiary complications.¹⁰ The at-risk age group is the 20-50 year old range, with the peak incidence in the early twenties.¹⁰ Recommendations for screening in the at-risk age group are from the initial visit only,²¹ to every five or six years,^{1, 10} to every five years,^{1, 10} to every two years.²² We recommend a serological test for syphilis beginning at age 20, or when the patient becomes sexually active, with each physical examination to age 50.

Gonorrhea culture. Gonorrhea is asymptomatic

in 75% of women⁶ and possibly 10% of men.¹⁷ Some feel that screening is not warranted because of the low morbidity from the disease and the inability of screening to eliminate the disease from the population.^{10, 21} Others feel that screening is warranted, and recommend it yearly from the time the female or the male become sexually active to as long as they remain so.²² Others feel that only the female should be screened from the time she becomes sexually active to age 35.¹ We recommend gonorrhea culture, beginning with the first pelvic examination, with each visit for a physical examination to age 44.

PKU. Screening for phenylketonuria is a universally accepted test in the neonatal period.^{5, 12, 19}

T4. Screening for hypothyroidism is recommended in the neonatal period.^{5, 19} We concur.

Chest x-ray (CXR). Because of the low cure rate (8% five-year survival) of lung cancer, regardless of the stage of detection, the American Cancer Society no longer recommends the CXR as a screening test for lung cancer.¹⁵ It should be kept in mind that abnormalities other than lung cancer (tuberculosis, change in heart size, non-malignant lung lesions, sarcoidosis, etc.) may be picked up on CXRs. The CXR has been recommended around age 35 (baseline) with subsequent CXRs at five to ten year periods.²⁴ We recommended a baseline CXR between the ages of 20 and 35, one with every physical examination after age 40 until age 65, and then one with every other physical.

EKG. A baseline EKG has been recommended at age 35-40 with repeats every five to ten years.²⁴ We recommend a baseline EKG between the ages of 20 and 35, followed by one with every other physical examination after age 40.

PPD. Skin testing for tuberculosis has been recommended from once,²¹ to every physical examination unless it is positive,²⁴ to every ten years.¹¹ We feel that a PPD should be done at age 12 months and every ten years after that.

Screening Procedures Not Recommended

Barium enema (BE). The BE is expensive, time-consuming, and involves a significant dose of radiation. For this reason, it is not recommended as a routine screening procedure.^{1, 9, 21-24}

Upper GI (UGI). The UGI was once used by some physicians as a screen for stomach cancer, a disease which is steadily declining. The test is expensive and time-consuming, and it offers a significant exposure to radiation. It is not recommended as a screening procedure.^{1, 9, 21-24}

Sputum cytology. Like the chest x-ray, sputum cytology on a regular basis does not improve the

long-term outlook for lung cancer.¹³ It is not recommended as a routine screening procedure.^{1, 8, 21-24}

Stress testing. Besides being time-consuming and expensive, stress testing gives a significantly high false result, both positive and negative.²⁴ It is not recommended for routine screening^{1, 8, 21-24} except for those over 35 years of age who wish to begin a strenuous exercise program.²⁴

Spirometry. Although spirometry may be useful for following the progression of the disease in patients with chronic obstructive pulmonary disease, it is not recommended as a routine screening procedure.^{1, 8, 21-24}

Endometrial biopsy. Most patients with endometrial cancer present early with bleeding. Mass screening would be unlikely to change this.²¹ Therefore, the American Cancer Society recommends that endometrial biopsy not be routinely performed, but done at menopause a single time for those patients at high risk for endometrial cancer (history of infertility, obesity, failure of ovulation, estrogen therapy).¹⁵ We concur.

Preventive Medicine Measures

Preventive activity may take place at any time in the natural history of a condition.¹ We will concern ourselves with primary prevention (immunization for infectious diseases, counseling individuals who have not yet begun to smoke about the hazards of smoking, etc.), and secondary prevention (detecting conditions, such as mouth cancer or hazardous habits such as smoking, to reduce morbidity and mortality). We recommend preventive measures for the following:

1. Infectious diseases (diphtheria, pertussis, typhoid, poliomyelitis, measles, mumps, rubella, influenza, pneumococcal diseases, and neonatal gonococcal ophthalmia)
2. Hemorrhagic disease of the newborn
3. Dental problems
4. Poor nutrition
5. Weight problems
6. Accidents
7. Unwanted pregnancy
8. Alcohol and drug abuse
9. Smoking
10. Cancer (breast, testicular, endometrial, mouth)

In addition, we recommend that each infant's mother be taught how to take a temperature and be given counseling on toilet training.

DPT, TOPV, MMR, Td. The following immunization schedule is universally recommended.^{5, 19, 20}

	MONTHS									YEARS																		
AGE	1	2	4	6	12	15	18	24	36	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19			
PE																												
Growth																												
Development																												
Hct																												
FBS																												
SS trait (blks)																												
Rub. titer																												
U/A																												
Nutrition																												
Car seat																												
How to take temperature																												
Poisons																												
Climbing																												
Toilet training																												
Dental care																												
Dental appt.																												
Sex counseling																												
Smoking, alc., drug counseling																												
Seat belts																												
Driving safety																												
Mens. hx																												
DPT																												
TOPV																												
PPD																												
MMR																												
Td																												
Other																												

Figure 1. Protocol for one month to 19 years.

DPT — 2 months, 4 months, 6 months, 18 months, preschool age.

TOPV — 2 months, 4 months, 18 months, preschool age.

MMR — 15 months

Td — Every ten years after DPT series.

Following interruption of the initial series, one need not start over but merely pick up where you left off. Individuals should be reimmunized for measles if the initial immunization was prior to 12 months of age, or before 1968. A URI is not a contraindication to immunization unless the individual is febrile. It should be remembered that a nonimmune adult can contract poliomyelitis from children immunized with TOPV.

Influenza immunization. Influenza vaccine should be given annually to individuals over 65 years old. In addition, individuals at high risk of complications (heart disease, chronic obstructive pulmonary disease, chronic renal disease, metabolic diseases, se-

vere chronic anemia or compromised immune mechanisms) should also receive the vaccine annually.¹⁴

Pneumococcal immunization. Indications for pneumococcal immunization are: (1) age 60 or over, (2) patients with chronic lung, renal or heart disease, (3) alcoholics, (4) diabetics, (5) individuals with sickle cell disease, (6) individuals who have had or plan to have a splenectomy, (7) prior to initiation of chemotherapy in patients with Hodgkins disease or leukemia. The vaccine should not be given to children under 2 years of age, to patients with active respiratory tract infection, or to pregnant women.¹³ It should be repeated every three years. This period will most likely be expanded to at least five years as the immune response from the vaccine is better studied.*

Silver nitrate. Silver nitrate is used routinely in the eyes of neonates to prevent the complications of

* Pneumococcal immunization has now been extended to five years.

For your patients' benefit...

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YOUR NEXT ANTIARTHRITIC
PRESCRIPTION,
PLEASE READ
THIS MESSAGE**



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RUFEN[®] (ibuprofen)

\$1.50 REBATE DIRECT TO YOUR PATIENTS ON EVERY PRESCRIPTION OF 100. REFILLS INCLUDED.

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Every bottle of 100 tablets of RUFEN 400 mg has a Rebate Coupon attached, with full instructions for redemption.

It has already been determined, through public opinion research, that most arthritic patients will appreciate direct rebate savings as much as they appreciate the results of ibuprofen therapy.

AND RUFEN IS PRICED LOWER TO BEGIN WITH.

Boots has already priced RUFEN lower to the wholesaler and the retailer. And if these savings are passed along, as they should be, your patient will receive the benefit of this lower price. Add these savings to the rebate, and your patients receive substantial relief from the costs of a medication many of them may take for years.



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You first came to know it as Motrin (ibuprofen), manufactured by Upjohn.

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Rufen®
(ibuprofen)

*Data on file.

†Contributions made to: International League Against Rheumatism.

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- RUFEN** CONTRIBUTES 25¢ PER REBATE TO ARTHRITIS RESEARCH.
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- RUFEN** (IBUPROFEN) IS BIOEQUIVALENT TO MOTRIN® (IBUPROFEN).*

I hope we've given you several good reasons to remember RUFEN the next time you prescribe ibuprofen.

If we haven't, or if you'd like to know more about Boots Pharmaceuticals or this program, please don't hesitate to drop me a line. Or call us directly at our toll-free number: (800) 551-8119. Louisiana residents, call (800) 282-8671.

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Sincerely,



John D. Bryer, President
Boots Pharmaceuticals, Inc.



Boots Pharmaceuticals, Inc.
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(ibuprofen)

INDICATIONS AND USAGE: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in the long-term management of these diseases. Safety and effectiveness have not been established for Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see **WARNINGS**).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see **CONTRAINDICATIONS**). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally; however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the **ADVERSE REACTIONS**.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: Coumarin-type anticoagulants. The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin. Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS

Incidence greater than 1%

Gastrointestinal: The most frequent adverse reaction is gastrointestinal (4% to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see **PRECAUTIONS**).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme. **Special Senses:** amblyopia (see **PRECAUTIONS**). **Hematologic:** leukopenia, decreased hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities. **Dermatologic:** alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** hemolytic anemia, thrombocytopenia, granulocytopenia bleeding episodes. **Allergic:** fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** gynecomasia, hypoglycemia. **Cardiovascular:** arrhythmias (Sinus tachycardia, bradycardia, and palpitations). **Renal:** decreased creatinine clearance, polyuria, azotemia.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

DOSAGE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flareups of chronic disease: Suggested dosage 400 mg t.i.d. or q.i.d.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain. Do not exceed 2,400 mg per day.

CAUTION: Federal law prohibits dispensing without prescription.

Boots Pharmaceuticals, Inc.
Shreveport, Louisiana 71106

AGE (YRS)	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45
PE																										
Wt																										
Ht																										
BP																										
Pap ♀																										
Pelvic ♀																										
Breast exam ♀																										
GC cult. ♀																										
Hct ♀																										
Hct ♂																										
FBS																										
Creatinine																										
STS																										
Chol/trig	/				/				/				/				/			/			/			/
U/A																										
Stool O.B.																										
CXR	ONCE																									
EKG	ONCE																									
Hearing test																										
Vision test																										
Tonometry																										
Mammography ♀																	ONCE									
PPD																										
Td																										
Mens. hx ♀																										
Teach breast/test. exam																										
Teach to report mouth sores																										
Wt. coun.																										
Exer. coun.																										
Alc/drug coun.	/				/				/				/				/			/			/			/
Smoking coun.																										
Other																										

Figure 2. Protocol for 20-45 years.

gonococcal eye infections.¹⁹

Vitamin K. Parenteral vitamin K is routinely given to neonates to prevent hemorrhagic disease of the newborn.^{5, 19}

Nutrition. We recommend nutrition counseling for preschool children ages 1, 2, 4 and 6 months and 1, 3 and 5 years of age. Because of the poor dietary habits of many preteens and teenage children, we recommend nutritional counseling also at ages 10 and 15. We do not routinely do nutrition counseling in adults, although a case could possibly be made for such counseling in the geriatric age group. This is left to the discretion of the physician.

Weight. Weight counseling is done in children as part of their growth and development evaluation. In adults we recommend weight counseling in all overweight adults with each physical examination.

Car seats. We recommend counseling on the use of the car seat at one month and again at 6 months of age.^{5, 12, 26}

Poisons. We recommend counseling on how to

avoid accidental poisoning at 6 and 18 months of age.^{5, 12, 26}

Climbing. We recommend counseling about climbing at 12 months of age. This includes information on child-proofing the house.^{5, 23}

Dental care. We recommend dental counseling at 1½, 10 and 15 years of age and a dental appointment at 2 years of age.^{5, 23} We leave follow-up dental appointments to the dentist. Dental counseling can be done at any time in adults if poor dental hygiene is noted on physical examination.

Sex counseling. We recommend sex counseling at ages 10 and 15 with appropriate materials for each age.^{5, 23}

Smoking, alcohol and drug counseling. We recommend smoking, alcohol and drug counseling in children at ages 10 and 15 years. Counseling is recommended in adults with each physical examination until age 53 and then every five years after that.

Seat belts. We recommend counseling about the use of seat belts at 2, 5, 10 and 15 years of age.^{5, 23}

AGE (YRS)	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70
PE																									
Wt																									
Ht																									
BP																									
Pap ♀																									
Pelvic ♀																									
Breast exam ♀																									
Hct																									
FBS																									
Creatinine																									
STS																									
Chol/trig		/			/			/				/				/				/					
U/A																									
Stool O.B.																									
CXR																									
EKG																									
Procto																									
Hearing test																									
Vision test																									
Tonometry																									
Mammography ♀																									
PPD																									
Td																									
Flu Vaccine																									
Pneu. Vaccine																									
Mens hx ♀																									
Teach breast/test. exam																									
Teach to report mouth sores																									
Teach to report postmen. bldg. ♀																									
Wt./exer. coun.		/			/			/				/				/				/				/	
Alc./smok. coun.		/			/			/				/				/				/				/	

Figure 3. Protocol for 46-70 years. The protocol is repetitive after age 65.

Additional counseling of adults can be done at any time deemed advisable by the physician.

Driving safety. We recommend counseling on driving safety at age 15.^{5, 23}

Breast examination. Female patients should be counseled to do breast self-examinations monthly. We recommend that the procedure be taught, and the need for the examination reinforced, at 20 and 25 years of age and every ten years after that.¹¹

Testicular exam. We recommend that the male be taught to do monthly testicular exams, with the procedure taught and reinforced at 20 and 25 years of age and every ten years after that.¹¹

Exercise and weight counseling. We recommend exercise and weight counseling with each physical examination to age 53, then every four years after that.

Reporting postmenopausal bleeding. We recom-

mend that patients be taught to report postmenopausal bleeding upon becoming postmenopausal or at ages 47 and 50 and every ten years after that.¹¹

Reporting mouth sores. To detect mouth cancer early, we recommend that patients be taught to report mouth sores at ages 41 and 44 and every ten years after that.^{7, 11}

How to take temperature. We recommend that mothers be taught how to take a temperature and instructed to buy a thermometer when the infant is two months old.⁵

Toilet training. We recommend that a mother be given instructions on toilet training a child when her baby is 18 months old.⁵

Pamphlets are available for most counseling topics. We recommend that these be used. A list can be obtained by writing the author.

Our protocols for ages 1 month — 19 years, 20-45

years and 46-70 years are summarized in Figures 1, 2, and 3, respectively. Procedures for individuals past age 70 are repetitive. These protocols are intended for office use, so neonatal procedures are not included. Blood pressure, scoliosis and strabismus are not included in these forms because they are part of our physical examination forms.

In summary, we feel that preventive medicine and periodic health screening are no longer luxuries, and should be part of every physician's routine. We have presented a birth to death protocol which we find useful. A complete set of forms, including age dependent physical examination forms, history forms, developmental screening forms, and graphs for growth and head circumference can also be obtained by writing the author. ★★★

2500 North State Street (39216)

References

1. Bass, F. and Grantham, R. P.: Preventive medicine. In Family Practice (Ed. by Rakel, R.E. and Conn, H. F.), Philadelphia, W. B. Saunders Co., 1980, pp. 103-122.
2. Report of the Canadian Task Force on Screening for Cervi-

- cal Cancer: Cervical cancer screening programs. J.Can. Med. Assoc. 114:1033, 1976.
3. Cohn, P. F., Gabbay, S. I. and Weglicki, W. B.: Serum lipid levels in angiographically defined coronary artery disease. Ann. Intern. Med. B4:241-245, 1976.
4. Dutton, J. J.: Sigmoidoscopy as a periodic screening test. J. Fam. Pract. 7:1041-1046, 1978.
5. Eggertsen, S. C., Schneeweiss, R. and Bergman, J. J.: An updated protocol for pediatric health screening. J. Fam. Pract. 10:25-37, 1980.
6. Fiumari, N. S.: The diagnosis and treatment of gonorrhea. Med. Clin. N. Am. 56:1105-1113, 1972.
7. Frame, P. S.: Periodic health screening in a rural private practice. J. Fam. Pract. 9:57-64, 1979.
8. Frame, P. S. and Carlson, J. S.: A critical review of periodic health screening using specific screening criteria. Part 1: Selected diseases of the respiratory, cardiovascular and central nervous systems. J. Fam. Pract. 2:29-36, 1975. Part 2: Selected endocrine, metabolic and gastrointestinal diseases. J. Fam. Pract. 2:123-129, 1975.
9. Frame, P. S. and Carlson, J. S.: A critical review of periodic health screening using specific screening criteria.
10. Frame, P. S. and Carlson, J. S.: A critical review of periodic health screening using specific screening criteria. Part 3: Selected diseases of the genitourinary system. J. Fam. Pract. 2:189-194, 1975.

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Hepatitis A Outbreak Related to a Day Care Center in Forrest County, Mississippi

CLAY HAMMACK, M.D., M.P.H., ABEL OCHOA, M.D., M.P.H.,
CHARLES HENDERSON, R.S., PAT FULLILOVE, R.N., AND GAIL FONDREN, R.N.
Jackson, Mississippi

VIRAL HEPATITIS REMAINS a major challenge for public health workers. In the United States alone more than 55,000 cases of the disease are reported each year; the true figure is believed to be much higher, perhaps ten times the reported figure. Hepatitis A virus is believed to be responsible for approximately 25% of all new cases of viral hepatitis that occur in the United States each year.¹

In the period August 6, 1980-December 1, 1980, a total of 27 hepatitis A (HA) cases were reported to the Forrest County Health Department (FCHD). A clinical diagnosis of each of the 27 cases was confirmed by demonstrating the presence of HA antibody (HAV Ab), predominantly IgM, signifying recent infection.

On August 8, two HA cases were reported to FCHD (index cases). Subsequently an investigation was conducted by Disease Control personnel, Mississippi State Board of Health.

The investigation showed that the first case, a 36-year-old white female, was the director of a local day care center (DCC). The second case was a 32-year-old white female nurse with a sibling in the same DCC. The onset of symptoms occurred during the same week for both cases. In view of the presumed exposure to other children and personnel in the DCC, specific recommendations were given as to: (a) proper hygiene and sanitation practices; (b) administration of human immune globulin (HIG) to each child and employee in the DCC as well as to the household contacts (HHC) of each case; and (c) stopping new admissions to the DCC until 30 days after the last reported case in employees or attendees in the DCC.

From the Southeast Public Health District VIII, Hattiesburg, MS.

The authors investigated a Hepatitis A outbreak associated with a local day care center in Forrest County, Mississippi. Over a four-month period a total of 27 cases occurred in persons closely related to the day care center. Twenty-three (85%) of the cases were household contacts or close relatives of children attending the day care center. Hepatitis A in household contacts was strongly related to contact with children under 2 years of age attending the day care center and to children who did not receive human immune globulin (HIG) in the three-week period after the presumed initial exposure ($P < 0.01$).

Continued surveillance revealed an increasing number of cases associated with the DCC, later than six weeks after the original administration of ISG (August 15, 1980). We determined at the same time that 48 of the children had not received HIG in the three-week period following exposure and that new children had been admitted to the DCC. Those children who had not received HIG were children whose parents either had not given permission to administer it or had asked a private physician for a certificate of exemption for HIG. Private physicians, based on history of intensity and duration of exposure, did extend some of those certificates. Eventually all 84 of the children, including the newly admitted children, received HIG, but 48 received it later than three weeks after presumed exposure in the DCC.

This circumstance provided us with the opportunity to compare HA attack rates of HHC of two groups of DCC children; those who received HIG within

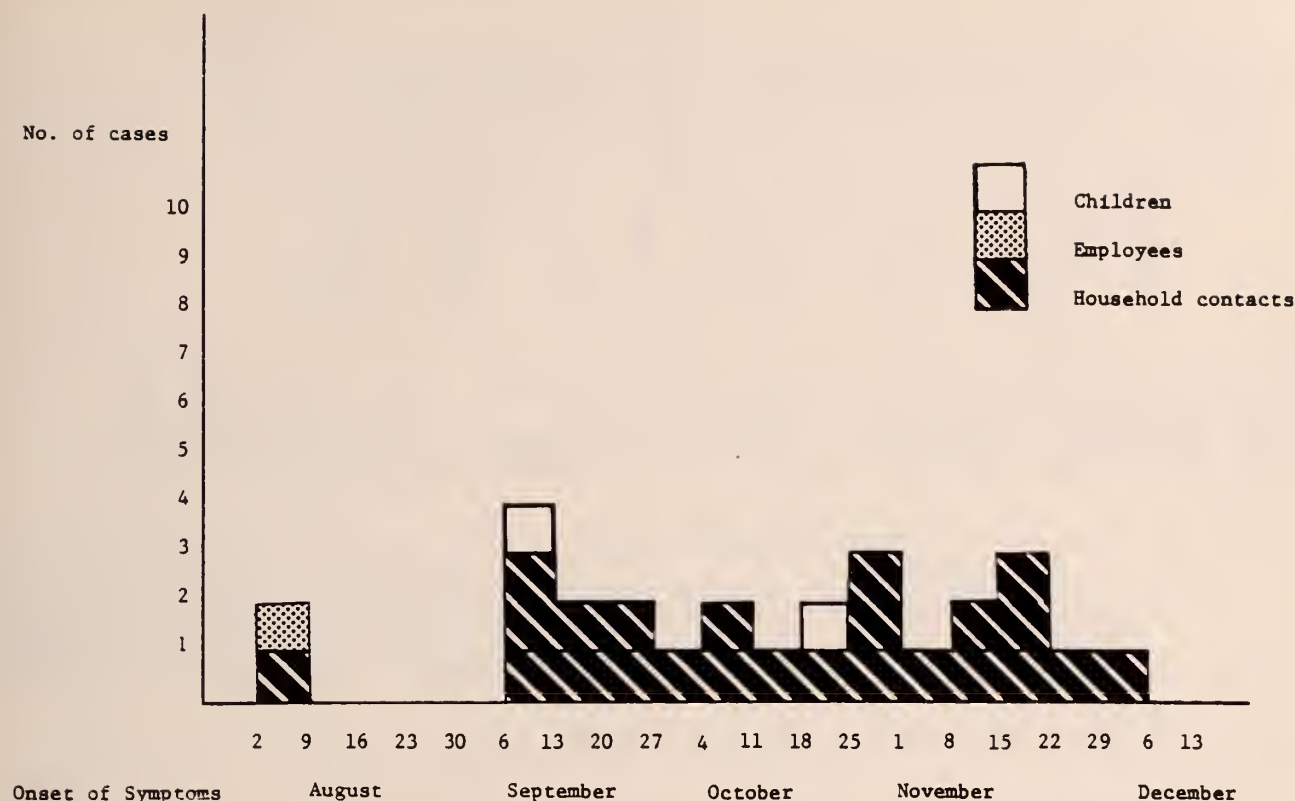


Figure 1. Hepatitis A in a day care center, Forrest County, M.S.

three weeks of exposure and those who received HIG after three weeks of exposure.

Children and Employees in DCC

There were 84 children enrolled in the DCC ranging in age from infancy to 10 years. The distribution by age group showing the number of children who received HIG before and after three weeks of exposure and the number of their HHC is shown in Table 1. The total number of HHC to each particular age group is also indicated.

There were also nine adult employees at the DCC. Human immune globulin was administered to all the employees and to HHC of the employee who was one of our index cases. The HIG was given within the three-week period after exposure. No cases were reported among their HHC.

Analysis of the Cases

Figure 1 illustrates the 27 cases by onset of symptoms.

Excluding the two index cases, of the remaining 25, 23 were adults who had household exposure secondary to a child who attended the DCC during the 12 weeks preceding the onset of illness and two were children with primary exposure (attendees to the DCC) during the six weeks before illness.

From Table 2 it can be seen that children under 2 years of age most likely transmit infection. This observation was consistently significant when we evaluated attack rates for both groups of HHC, that is, HHC exposed to children who received HIG in the three-week period after exposure and HHC exposed to children who did not receive HIG in that period (see Tables 3 and 4).

We found that 124 (56.0%) of the 223 HHC were exposed to children who received HIG within three weeks after exposure. The remaining 99 were exposed to children who did not receive HIG in that period. Attack rates for both groups are shown in Tables 3 and 4 respectively, and a comparison of attack rates in both groups is presented in Table 5.

TABLE 1
NO. OF HHC OF CHILDREN WHO RECEIVED AND DID NOT RECEIVE HIG ACCORDING TO AGE GROUP

Age Group	HIG Given Three Weeks Before	HHC	HIG Given After Three Weeks	HHC	Total No. Children	Total No. HHC
0-2	6	16	18	41	24	57
2-3	10	37	13	32	23	69
3 or more	<u>20</u>	<u>71</u>	<u>17</u>	<u>26</u>	<u>37</u>	<u>97</u>
Total	36	125	48	99	84	223

TABLE 2
OVERALL ATTACK RATES

Age Group of Child in DCC	Cases	HHC	Attack Rates
0-2	16	57	28.0%*
2-3	2	69	2.8%
3 or more	<u>1</u>	<u>97</u>	<u>1.0%</u>
Total	19	223	8.5%

* Statically significant at the 1% level, test of hypotheses of proportions.

TABLE 3
ATTACK RATES IN HHC EXPOSED TO CHILDREN WHO
RECEIVED HIG WITHIN THREE WEEKS AFTER EXPOSURE

Age of Group of Child in DCC	Cases	HHC	Attack Rates
0-2	4	16	25.0%
2-3	1	37	2.7%
3 or more	<u>0</u>	<u>71</u>	<u>0%</u>
Total	5	124	4.0%

TABLE 4
ATTACK RATES IN HHC EXPOSED TO CHILDREN
WHO DID NOT RECEIVE HIG WITHIN THREE WEEKS
AFTER EXPOSURE

Age Group of Child in DCC	Cases	HHC	Attack Rates
0-2	12	41	29.2%
2-3	1	32	3.1%
3 or more	<u>1</u>	<u>26</u>	<u>4.5%</u>
Total	14	99	14.1%

TABLE 5
ATTACK RATES IN HHC OF CHILDREN WHO RECEIVED HIG
WITHIN THREE WEEKS AFTER EXPOSURE COMPARED TO
ATTACK RATES IN HHC OF THESE CHILDREN WHO DID
NOT RECEIVE HIG IN THAT PERIOD

	Cases	HHC	Attack Rates
Exposed to children who received HIG <3 weeks	5	124	4.0%
Exposed to children who did not receive HIG >3 weeks	<u>14</u>	<u>99</u>	<u>14.1%</u>
Total	19	223	8.5%

Recommendations

1. Human immune globulin HIG should be administered to all children and employees in a DCC within three weeks after a proven exposure to a HA case (employee or attendee).

2. A two-way communication line should be established among health departments/DCC administrator and parents, as well as between health departments and private physicians, as part of a strict surveillance system after proven exposure to HA in the DCC in an effort to eliminate delay in reporting

cases and/or lack of awareness of the problem among the sectors involved.

3. No new children should be admitted within seven weeks after a case in employee or attendee is reported. Administration of HIG before admission if admitted in that period may be an alternative.

4. In the event that surveillance shows that the first recommendation has not been followed completely, after six weeks of initial exposure an effort should be made to identify those young children with

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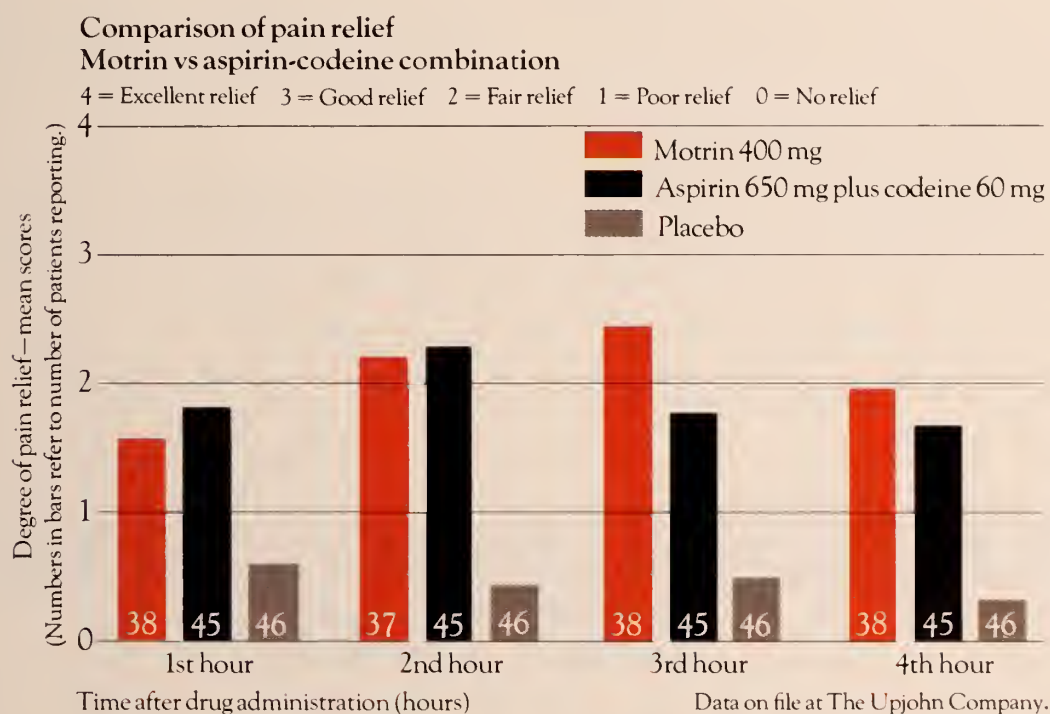
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A *Motrin* 400 mg dose relieved postsurgical dental pain as effectively as a combination of 650 mg aspirin and 60 mg codeine (two aspirin-with-codeine No. 3 tablets) in a study of 129 patients.

In this double-blind, placebo-controlled, randomized study, no statistically significant difference in relief of pain was noted at 1, 2, and 4 hours between the *Motrin* and aspirin-with-codeine groups...

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Active treatment was significantly more effective ($p < 0.0001$) than placebo at all time intervals.



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Motrin[®] (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin[®] Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* Used concomitantly may decrease Motrin blood levels.

Coumarin: Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea, epigastric pain, heartburn, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness, headache, nervousness. **Dermatologic:** Rash (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain. Do not exceed 2400 mg per day.

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HA who were clinically unrecognizable. A rational approach would be to obtain a serum HA antibody test in those children who did not receive HIG within three weeks after exposure (especially children under 2 years). If HA antibody is detected (predominantly IgM or both IgM and IgG), then HIG should be administered to their HHC immediately.

5. Maintenance of appropriate hygienic standards, particularly washing the hands of staff and of young children who cannot adequately wash themselves, should be emphasized. (HA is probably spread only by the oral/fecal route, consequently it is associated with epidemics where sanitary conditions are suboptimal and is most common in point-source outbreaks.)

A statistical association between not having received HIG (child) within three weeks after exposure and appearance of disease in HHC was found at the 1% level (test of hypothesis of proportions).

Conclusions

Our investigations confirmed the characteristics common to DCC-related HA outbreaks reported in previous studies:²⁻⁴

- a. Hepatitis A in children of day care age is usually asymptomatic.
- b. Household contacts are often infected as a consequence of spread within the center, and constitute the majority of recognized cases.
- c. Children age 2 years or younger are most likely to transmit infection to household contacts.

By administration of ISG to all children and employees in the DCC within three weeks after exposure, asymptomatic HA (in children) and transmission of the disease to HHC can be significantly reduced. ★★★

400 Forrest Street (39401)

References

1. U.S. Department of Education, and Welfare, Public Health Service, National Institute of Health, NIH Publication No. 79-143, August 1979.
2. Hadler, S. C., Webster, H. M., Erben, J. J. and Swanson, T. E.: Hepatitis A in day-care centers. A community-wide assessment. *N. Engl. J. Med.* 302:1222-1227, 1980.
3. Storch, T. and McFarland, L. M.: Viral hepatitis associated with day care centers. *JAMA* 242:1514-1518, 1979.
4. CDC MMWR, Vol. 29, No. 47, November 28, 1980.
5. Miller, D. J.: Viral hepatitis. *Postgrad. Med.* 68(3):137-147, September 1980.

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The President Speaking

Freedom of Choice Requires a Choice

R. FASER TRIPLETT
Jackson, Mississippi

A few days ago a friend expressed dismay over a change in federal regulations for the Medicaid program which allows the program to assign a recipient to a specific physician and contract with that physician for his services. "The patient will lose his freedom to select his own physician!" he exclaimed. He's right, of course, but his observation led me to reflect on the meaning of "freedom of choice" in health care.

Our profession has stressed in its ethical pronouncements and its statements concerning various health delivery mechanisms that a patient should be free to choose a physician. But what if there is no "choice" for the patient? Or more particularly with respect to my friend's comment, what if there are no physicians or only a few physicians or only a "Medicaid mill" to see Medicaid recipients in an area? What then does "freedom of choice" mean? Perhaps the change in the Medicaid regulation and many other changes being proposed on the health scene today have come forth in part because there is a feeling that there really is no "freedom of choice."

One of the strongest bonds for goodwill that our profession has enjoyed with the public throughout its existence has come from the belief — both experienced and implied — that the primary concern of the profession is to care for the sick. In this day of Medicaid regulations, malpractice suits, third party payments, etc., perhaps that concern has at times been hidden if not dimmed.

Surely, however, any freedom of choice pronouncements that we make on behalf of patients must also include an obligation on our part to see the sick regardless of extracurricular matters affecting that purpose. In other words "freedom of choice" does require a choice, and we must all be part of that choice with respect to health care.

★★★

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXIII, Number 2

FEBRUARY 1982

Staging Laparotomy for Hodgkin's Disease

The therapy of Hodgkin's disease, once a uniformly fatal lymphoreticular malignancy, now allows the patient long-term disease-free survival, and in many instances a complete cure. More than eighty percent of all patients now will live more than five years.

The diagnosis ordinarily is made by biopsy of an enlarged lymph node. It is particularly important that suspicious extra-nodal sites be biopsied, because the finding of visceral disease markedly alters the therapeutic approach.

Staging laparotomy has become extremely popular in the diagnostic evaluation of patients with Hodgkin's disease. Although it is a proper procedure in certain instances, it is by no means indispensable and should never be undertaken routinely. Laparotomy and splenectomy should be performed only if decisions in management depend on the identification of abdominal disease. Staging laparotomy is not necessary in those patients with Clinical Stage I and II who are to receive total nodal irradiation.

Laparotomy for the staging of Hodgkin's disease is a major surgical procedure with significant risks and should be performed by surgeons in concert with the therapeutic team of hematologists, oncologists and radiotherapists.

Once a determination to do a staging laparotomy has been made, extremely careful attention must be paid as to the completeness of the study. It should always include detailed inspection of the abdomen and splenectomy. Liver biopsy should include ample wedge biopsy of the right lobe and needle biopsies of the right and left lobes and biopsy of any gross lesions. After inspection and palpation of nodal groups, biopsies of the right and left para-aortic and iliac nodes should be done, regardless of their character on palpation and/or appearance on lymphangiogram. In addition, search for and biopsy of splenic hilar, celiac, porta hepatis and mesenteric nodes always should be carried out since positive findings have profound therapeutic implications. Radiopaque

clips should be left at all biopsy sites to aid in proper design of radio ports and to follow response to subsequent therapy.

Perhaps the most significant finding from exploratory laparotomy and splenectomy is the frequency and character of splenic involvement. About twenty-five percent of patients without any clinical evidence of splenic abnormality will be found to have histologically-proven Hodgkin's disease, even with a normal size spleen. In addition, the spleen frequently is found to be the only site of involvement below the diaphragm.

Laparotomy for the staging of Hodgkin's disease is a major surgical procedure with established morbidity and mortality. Reported mortality has ranged from 0.5 percent to 6.6 percent. Morbidity includes wound infections, subphrenic abscess, pulmonary emboli, stress ulcers, pulmonary infections, and wound dehiscence. The overall morbidity rate is 12.8 percent.

During the past fifteen years there has been a dramatic improvement in the prognosis of patients with Hodgkin's disease. Much of this success is due to improved methods of treatment; i.e., radiotherapy and chemotherapy. Only with careful and precise staging prior to initial therapy can the physician achieve maximum benefit from the improved forms of therapy now available.

GEORGE H. MARTIN, M.D.
Associate Editor

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Council Announces Plans for MSMA's 114th Annual Session, May 2-6

Members of the MSMA Council on Scientific Assembly are completing plans for the association's 114th Annual Session, set for May 2-6 at the Biloxi Hilton. In addition to a full schedule of scientific meetings and sessions of the House of Delegates, the agenda for this year's meeting includes several special events to commemorate the association's 125th Anniversary.

The historical tone of the meeting will receive early emphasis through a topic to be presented at one of the opening day's scientific sessions. The topic — the Shroud of Turin — will be discussed during the Section on Pathology meeting on Sunday, May 2.



Abigail Van Buren ("Dear Abby") will be guest speaker at the MSMA/MSMA Auxiliary banquet, Tuesday, May 4.

The Shroud of Turin, purported to be the burial garment of Jesus Christ, has been a topic of discussion and debate for more than six centuries. That discussion has intensified in recent years with the application of sophisticated scientific tests to determine the authenticity of the ancient artifact.

Dr. Robert Bucklin, a Los Angeles deputy medical examiner and a member of the research team which has been conducting tests on the relic since 1978, will present his interpretation of the team's findings.

The investigation of the Shroud is regarded as an event of historical, scientific, and ecclesiastical significance, and Dr. Bucklin's presentation is expected to draw considerable public interest in Mississippi. At press time, plans call for a repeat session on Sunday afternoon to accommodate the general public and those interested physicians who may have conflicting meetings during the earlier session.

In addition to the Section on Pathology, six other scientific sections have scheduled meetings on Sunday, including the sections on anesthesiology, dermatology, EENT, orthopedic surgery, psychiatry and radiology.

Tuesday's scientific program includes sessions by the sections on medicine, preventive medicine, and surgery. Highlighting the Section on Surgery meeting is the presentation of the second annual James Grant Thompson Memorial Lecture. The scientific meetings conclude on Wednesday, May 5, with sessions conducted by the sections on family practice, ob-gyn, pediatrics, and urology. Adding to the educational opportunities are several presentations scheduled by specialty societies. A number of scientific exhibits will be on display during the week, as well.

During the five-day convention MSMA members, their spouses and guests will have the opportunity to view a special exhibit of medical artifacts. The exhibit is planned as part of the association's 125th anniversary celebration. Plans are underway, also, for other events which will recognize the historic occasion, including the presentation of a third

volume of the Mississippi State Medical Association history. Other activities during the week will direct attention to one of the association's major anniversary projects, the opening of a country doctor's office at the Mississippi Agriculture and Forestry Museum in Jackson.

Highlighting the special events calendar is the MSMA/MSMA Auxiliary banquet scheduled for Tuesday night. Nationally syndicated columnist and lecturer Abigail Van Buren ("Dear Abby") will be guest speaker.

The annual MSMA fellowship party, scheduled for Wednesday night, will be a special occasion to celebrate the association's 125th anniversary and to honor the MSMA past presidents. Dr. and Mrs. Faser Triplett will host the annual President's Reception, set for Sunday night.

The annual tennis and golf tournaments have been scheduled again this year, along with the deep-sea fishing rodeo which was so popular last year.

Medical alumni organizations have scheduled parties on Monday evening. Preliminary plans indicate that the University of Mississippi medical alumni will have their annual seafood buffet at the Royal D'Iberville that evening, as well as individual class reunion dinners on Sunday night.

Although the 114th Annual Session officially opens on May 2, there will be a special seminar for MSMA members and spouses on Saturday, May 1. The topic of the seminar is financial planning, and the session will be conducted by representatives of the AMA's Department of Practice Management.

Included among the many specialty organizations and medical-related groups which have scheduled meetings in conjunction with the MSMA Annual Session are the Mississippi Medical Fraternal and Educational Society and the Mississippi Foundation for Medical Care, which will hold their annual meetings on Sunday and Monday afternoons, respectively.

MSMA delegates will take action on reports and resolutions, elect new officers, and hear an address by Dr. Daniel T. Cloud, AMA President, during sessions on Monday and Thursday. The 114th Annual Session will conclude at the end of Thursday's House of Delegates meeting.

The MSMA Auxiliary will conduct its 59th Annual Session during the week. Mrs. John Estess of Hollandale is president and Mrs. James Martin of Ocean Springs is president-elect.

More details about the 114th Annual Session will be included in upcoming editions of the "Blue Sheet" and in the March and April issues of JOURNAL MSMA.

Dr. John Jackson Named UMC Department Chairman

Dr. John F. Jackson has been named chairman of the Department of Preventive Medicine at the University of Mississippi Medical Center. The Kosciusko native joined the Medical Center faculty in 1964.

Dr. Jackson succeeds Dr. Thomas Brooks who had chaired the department for 29 years before his retirement in June, 1981. Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean, announced Dr. Jackson's appointment following approval by the Board of Trustees, State Institutions of Higher Learning.

Dr. Jackson earned the B.A. degree at the University of Mississippi and the M.D. at Tulane University School of Medicine where he also served on the faculty.

He interned at Philadelphia General Hospital and later took residency training and was named a National Cancer Institute research fellow at the Mississippi Medical Center.

Dr. Jackson has studied at the Institute for Medical Genetics in Uppsala, Sweden, and has done specialty research at the Population Genetics Laboratory at the University of Hawaii. His primary research and teaching interests are in medical genetics.

Author of 57 scientific papers, Dr. Jackson is a member of the American Federation for Clinical Research, the American Society of Human Genetics and the Southern Society for Clinical Investigation. In 1973, he presented the Harold Cummins Distinguished Alumnus Lecture at Tulane.

114th Annual Session

May 2-6, 1982

Biloxi Hilton

Mark Your Calendars Now

Medico-Legal Brief

Hospital Held Liable

A Pennsylvania appellate court ruled that a hospital could be held liable for the negligence of a physician who was an independent contractor.

The suit arose when a patient was admitted to a hospital from the emergency room on Nov. 17, 1972, for treatment of a severe nosebleed. While in the hospital, he suffered delirium tremens and became violent. Six days later, the physician on call was summoned to the patient's room because of his combative and violent actions. The physician administered a series of drugs to calm him. After the physician left the hospital that evening, the patient suffered a cardiac arrest and, despite resuscitation attempts, died.

The patient's estate sued the physician and the hospital for wrongful death. A jury decided the

physician was not an employee of the hospital and the court rendered a verdict for the physician and the hospital. The appellate court affirmed, but the state supreme court remanded the case for a further determination.

On remand, the appellate court said that the trial court erred in failing to instruct the jury that the hospital could be found liable for the negligence of the physician. The court said the hospital could be liable on the theory of ostensible agency. The jury could have concluded that the patient relied on the hospital, rather than the physician himself, for treatment. In addition, the court said, the jury could have found that the hospital held out the physician as its employee by providing his services for dealing with emergencies within the hospital. — *Capan v. Divine Providence Hospital*, 430 A. 2d 647 (Pa. Super. Ct., Oct. 10, 1980; reargument denied, June 12, 1981)

Are the results of
\$100 million worth of
government-funded research
on hypertension
worth reading about?



MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 13-17, 1982, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

State and Local

Mississippi State Medical Association, 114th Annual Session, May 2-6, 1982, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, June 30-July 3, 1982, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkin-son.

Central Medical Society, 1st Tuesday, January, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jack-son. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarks-
dale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 3rd Wednesday, January, May, and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. J. Barry Gilbert, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Robert L. Coggin, Pres. and Secy., 965 Avent Dr., Grenada 38901. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, Au-
gust, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Pano-
la, State, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March,

June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, Septem-
ber, December. Albert H. Laws, Secy., 816 Second Ave. North, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, June, September, December. Robert D. Holbert, Secy., P.O. Box 1502, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Douglas F. Thomas, Secy., 415 South 28th Ave., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organiza-
tions have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Com-
mittee on Continuing Medical Education. Information concern-
ing CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly
Mississippi State Medical Association
735 Riverside Drive
Jackson, MS 39216

North Mississippi Medical Center
830 Gloster Avenue
Tupelo, MS 38801

Forrest General Hospital
Box 1897
Hattiesburg, MS 39401

Mississippi Baptist Hospital
1225 N. State Street
Jackson, MS 39201

Gulf Coast Community/Gulfport
Memorial Hospital Consortium
4642 W. Beach Boulevard
Biloxi, MS 39531

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Delta Medical Center
Greenville, MS 38701

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Biloxi Regional Medical Center
1559 Lafayette St.
Biloxi, MS 39533

Mississippi Radiological Society
316 Medical Arts Building
Jackson, MS 39201

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

Mercy Regional Medical Center
100 McAuley Drive
Vicksburg, MS 39180

North Panola County Hospital
Drawer 160
Sardis, MS 38666

Singing River Hospital
2809 Denny Avenue
Pascagoula, MS 39567

Magnolia Hospital
Alcorn Drive
Corinth, MS 38834

Greenwood Leflore Hospital
1508 Leflore Avenue
Greenwood, MS 38930

South Washington County Hospital
Drawer 398
Hollandale, MS 38748



Dr. Arl Van Moore, Jr., left, presented the annual Boswell Lecture during the Mississippi Thoracic Society meeting and scientific session. Dr. Moore, whose topic was computerized body tomography in chest diseases, is assistant professor of radiology at Duke University Medical Center. With him are Dr. Brent Harrison, UMC professor of radiology and department chairman, and Dr. Robert P. Henderson of Jackson, program coordinator. Sponsors were the Mississippi Lung Association, the Mississippi Thoracic Society, the UMC School of Medicine Department of Medicine pulmonary division, the Department of Radiology and the Division of Continuing Health Professional Education.

UMC Announces Faculty Appointments

Two assistant professors have joined the faculty at the University of Mississippi School of Medicine.

Dr. Paul Parker was named an assistant professor of pediatrics and Dr. Johnny Worley joined the family medicine faculty.

Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean, announced the appointments following approval by the Board of Trustees, State Institutions of Higher Learning.

Dr. Parker, a graduate of the University of Mississippi, earned the M.D. at the UMC School of Medicine. He interned and took residency training at the Medical Center and held a fellowship at Vanderbilt University Hospital prior to joining the faculty.

Dr. Worley earned the B.A. at the University of Texas and the Ph.D. at Texas Christian University. He held a postdoctoral fellowship at the Psychobiology Research Center at Florida State University and had been clinical director of Mental Retardation Services in Corpus Christi, Texas, since 1978.

In 1977, when
the Veterans Administration
compared Step-2
regimens in 450 mild
hypertensive patients,
which regimen was
proven most effective?'



POSTGRADUATE CALENDAR

March 11-13

SURGICAL FORUM IX

Holiday Inn Downtown, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Surgery and the Medical Center Division of Continuing Health Professional Education.

Coordinator: J. Harold Conn, M.D., professor of surgery, University of Mississippi School of Medicine, and chief of the division of surgery, Veterans Administration Medical Center.

An internationally recognized guest faculty will join Medical Center lectures in presenting this seminar for the practicing surgeon. The program will include lectures, panel discussions with written questions from participants, and breakfast conferences. Topics include surgical trauma, general surgery, and a surgical update. Fee: \$250. Credit: 17 contact hours (1.7 CEU), Category I of the AMA Physician's Recognition Award. Advance registration required.

March 25-26

FOURTH ANNUAL NEUROLOGY SPRING SYMPOSIUM

Emphasis on Seizure and Sleep Disorders

Holiday Inn Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Neurology and Neurosurgery, the Veterans Administration Medical Center Neurology Service and the Medical Center Division of Continuing Health Professional Education.

Coordinator: Shri K. Mishra, M.D., associate professor of neurology, University of Mississippi School of Medicine, and chief of the neurology service, Veterans Administration Medical Center.

This symposium will provide an update on seizures and sleep disorders for neurologists, neurosurgeons, internists, pediatricians, psychiatrists and family practitioners. Sessions include diagnosis and treatment of seizure disorders, classification of sleep disorders and sleep apnea. Fee: \$150. Credit: 11.25 contact hours (1.125 CEU), Category I of the AMA Physician's Recognition Award; AAFP.

April 3

THIRD ANNUAL SPRING SONIC SYMPOSIUM

University Medical Center, Jackson

Sponsored by the Mississippi Ultrasound Society and the University of Mississippi Medical Center Division of Continuing Health Professional Education.

Coordinator: Sandra A. Rhoden, M.D., president, Mississippi Ultrasound Society.

This course is designed to update the radiologist's and sonographer's knowledge of diagnostic ultrasound by covering the state of the art and current diagnostic procedures. Sessions include sonography of the placenta, ultrasonography of the jaundiced patient and noninvasive vascular studies emphasizing carotid ultrasound. Fee: \$125 for physicians and \$45 for sonographers. Credit: 6.5 contact hours (.65 CEU), Category I of the AMA Physician's Recognition Award.

O and O Society Will Meet in April

The 1982 annual meeting of the Louisiana-Mississippi Ophthalmological and Otolaryngological Society will be held April 15-17, at the Broadwater Beach Hotel in Biloxi.

The meeting features scientific presentations by leaders in the fields of both ophthalmology and otolaryngology. Also included are technical exhibits, social functions and golf, tennis and sailing.

The meeting qualifies for eight hours of Continuing Medical Education credit in Category 1.

The current officers of the society are Thomas P. Raggio, M.D., Baton Rouge, LA, president; Patrick L. Pierce, M.D., Gulfport, MS, president-elect; and Wilson E. Moak, M.D., Jackson, MS, secretary-treasurer.

For more details, contact Ben Davis, CAE, Executive Secretary, La.-Miss. O&O Society, P.O. Box 12314, Jackson, MS 39211, (601) 956-7787.

DOCTORS HELPING DOCTORS

Voluntary, tax deductible contributions to MSMA's Disabled Doctors Program may be made to the Caduceus Club of Mississippi. P.O. Box 5229, Jackson, MS 39216.

UMC Announces Faculty For Neurology Symposium

The University of Mississippi Medical Center's fourth annual neurology symposium, slated for March 25-26, 1982, in Jackson, will focus on seizures and sleep disorders.

The symposium is designed for neurologists, neurosurgeons, internists, pediatricians, psychiatrists and family practitioners. All sessions will be at the Holiday Inn Medical Center in Jackson.

Guest faculty for the program are Dr. Paul H. Crandall, professor of surgery/neurosurgery and professor of neurology at the UCLA School of Medicine; Dr. Charles P. Pollak, assistant professor of neurology at Albert Einstein College of Medicine and co-director of the Sleep-Wake Disorders Center at Montefiore Hospital and Medical Center; and Dr. Richard D. Walter, professor of neurology and

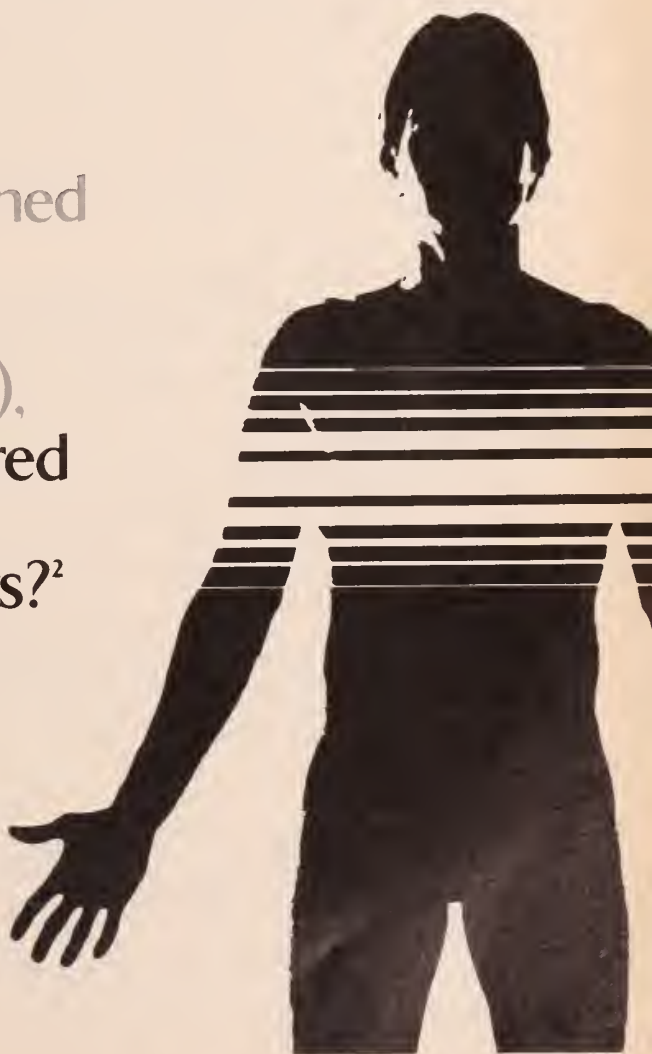
chairman of the department at UCLA School of Medicine and director of Reed Neurological Research Center.

Sessions include diagnosis and treatment of seizure disorders, classification of sleep disorders and sleep apnea. Audience participation in round table discussions following each session is encouraged.

Sponsors are the University of Mississippi School of Medicine Departments of Neurology and Neurosurgery, the Veterans Administration Medical Center Neurology Service and the Medical Center Division of Continuing Health Professional Education. Dr. Shri K. Mishra, UMC associate professor of neurology and chief of neurology service at the VA Medical Center, is course coordinator.

Course fee is \$150. Continuing education credit is offered. For more information, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS Phone: (601)987-4914.

In 1979, when results were published for the five-year, 10,000-patient Hypertension Detection and Follow-up Program (HDFP study), which Step-2 regimen was preferred and was deemed effective without significant adverse effects?²



Keesler Will Host Forensic Dentistry Seminar

What the popular television series "Quincy" has done for medical examiners hasn't yet happened for forensic dentists.

Their role remains obscure to the general public, even though they, too, play major roles in criminal cases and the identification of the dead.

A University of Mississippi School of Dentistry and Keesler AFB Medical Center seminar March 5-6 in Biloxi is designed to help law enforcement officials, pathologists and other dentists better understand and use the expertise of forensic dentists.

Course coordinator Dr. Sigurds Krolls, chairman of the UMC School of Dentistry's oral pathology/oral radiology department, says that forensic dentistry is based on the individuality of each set of teeth. Even though fingerprints are still the most conclusive means of identification, they are often unavailable, especially if the body has been burned or the tissue has degenerated.

Colonel Edward W. Rogers, Keesler's dental services chief, is seminar director for Keesler Air Force Base. Joining Dr. Krolls on the program are Dr. Kenton S. Hartman, chairman of the department of oral pathology at Wilford Hall Medical Center, Lackland Air Force Base; Dr. Edward M. Rehak, director of the laboratory at Gulf Coast Community Hospital in Biloxi; and Dr. James Fleming, UMC associate professor of pediatric dentistry and chairman of the department.

Sessions include an overview of forensic pathology, means of identification, evaluating bite marks, and the battered child syndrome. Dr. Hartman will relate his experiences in identifying victims of the mass suicide at Guiana and the plane crash on Canary Island.

The program is designed for dentists, medical pathologists, coroners, law enforcement personnel, field investigators and other forensic scientists. All sessions will be at Keesler Air Force Base Medical Center in Biloxi.

Course fee is \$100. For registration information, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone: 987-4914.

JOURNAL MSMA encourages your participation. Comments, inquiries and suggestions are invited.

PERSONALS

HANS ADAMS of Biloxi has been elected to fellowship in the American College of Physicians.

WILLIAM BATES of UMC was visiting professor at Tulane University and at the Medical College of Wisconsin in December.

HOWARD CHEEK, JAMES GORDON, KENNETH REED, and J. GEORGE SMITH of Jackson announce the association of ANDREW B. BROWN for the practice of otolaryngology, maxillofacial surgery and facial plastic surgery, and announce the relocation of their offices to 2630 Ridgewood Road.

A. WALLACE CONERLY of UMC has been named to a second four-year term on the board of trustees of the National Board for Respiratory Therapy, as representative of the American Thoracic Society.

GLEN GRAVES of Jackson and UMC presented a program on stabilization of the newborn to the medical staff at Winston County Community Hospital in Louisville.

WILLIAM MAYERS announces the opening of his office for the practice of urology at Hospital Road in Starkville.

W. W. PEARSON of Natchez announces the association of DOUGLAS MCATHEY for the practice of anesthesiology.

WILLIAM PONTIUS of Biloxi was elected chief of staff of Biloxi Regional Medical Center.

PHILIP ROGERS of Hattiesburg has been appointed clinical assistant professor of medicine (Division of Nephrology) at UMC.

ANUPAM ROUTH of Jackson and UMC presented a paper at the annual meeting of the Radiologic Society of North America in Chicago.

JAMES SONES of Jackson was elected to fellowship in the American College of Physicians.

JAMES STINGILY of Hazlehurst has been recertified by the American Academy of Family Physicians.

W. W. WALLEY of Waynesboro announces the association of THOMAS R. POUNDS for the general practice of medicine.

WILLIAM WHITEHEAD of Hattiesburg presented a poster paper at the annual meeting of the Southern Medical Association in New Orleans.

NEW MEMBERS

AZIZ, NASIM A., Port Gibson. Born Pakistan, June 15, 1940; M.D., Pakistan, 1965; interned Sirgung Ram Hospital, Lahore, Pakistan, one year; ob-gyn residency, Tulane, New Orleans, 1967-70; elected by Claiborne County Medical Society.

BARTEE, HARRY A., SR., Canton. Born Ocean Springs, MS, Feb. 1, 1943; M.D., University of Mississippi School of Medicine, 1976; interned and family practice residency, University Medical Center, Jackson, 1976-79; elected by Central Medical Society.

BERG, ROBERT JOHN, Laurel. Born Jackson, TN, Aug. 11, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned Roanoke Memorial Hospital, Roanoke, VA, one

year; surgery residency, University of Virginia, Charlottesville, 1975-76; surgery residency, Roanoke, 1976-80; elected by South Mississippi Medical Society.

BROOKS, MARK FRANKLIN, Brandon. Born Henderson, TX, Apr. 13, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and family medicine residency, University Medical Center, Jackson, 1978-81; elected by Central Medical Society.

DISHONGH, CHARLES RANDALL, Brandon. Born Valpariso, FL, Dec. 7, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned and surgery residency, University Medical Center, Jackson, 1976-79; elected by Central Medical Society.

GUYTON, BARNEY JOE, Jackson. Born Blue Mountain, MS, Apr. 30, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned, internal medicine residency, and fellowship

In 1980, when the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure published their recommendations, which Step-2 regimen best met their criteria for effectiveness, safety, simplicity of titration, convenience, and economy?³



in gastroenterology, University Medical Center, Jackson, 1976-82; elected by Central Medical Society.

HARRIS, JOHN STEPHEN, Meridian. Born Jonesboro, AR, Oct. 21, 1947; M.D., University of Tennessee College of Medicine, Memphis, 1972; interned and ob-gyn residency, National Naval Medical Center, Bethesda, MD, 1972-77; elected by East Mississippi Medical Society.

HENDRIX, RONNIE EUGENE, Yazoo City. Born Natchez, MS, Jan. 20, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned University Medical Center, Jackson, one year; elected by Central Medical Society.

HOLLY, SANDRA FAYE, Jackson. Born Jackson, MS, June 16, 1947; M.D., Howard University College of Medicine, Washington, DC, 1973; interned District of Columbia General Hospital, one year; elected by Central Medical Society.

HORN, F. LEE, Houston. Born Houston, MS, Nov. 14, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned University Medical Center, Jackson, one year; elected by Northeast Mississippi Medical Society.

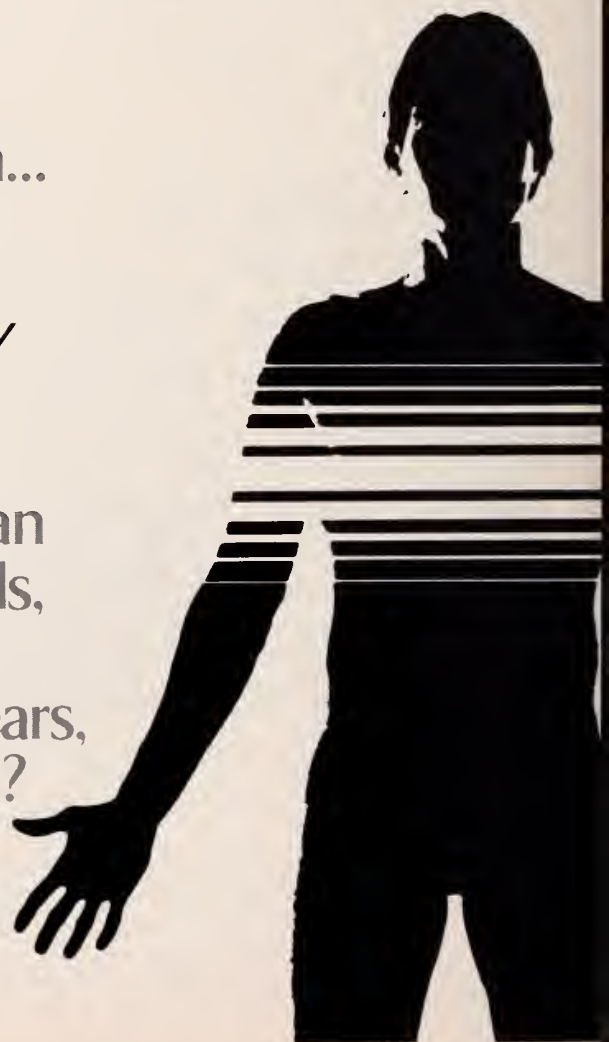
HOWELL, THOMAS ROBERT, Laurel. Born Ellisville, MS, Feb. 15, 1936; M.D., University of Tennessee College of Medicine, Memphis, 1965; interned Mobile General Hospital, Mobile, AL, one year; surgery residency, Roanoke Memorial Hospital, Roanoke, VA, 1968-69; surgery residency, Baptist Hospital, Birmingham, AL, 1976-79; elected by South Mississippi Medical Society.

KENNEDY, ROBERT ALEXANDER, Oxford. Born Jackson, MS, Apr. 30, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned and ob-gyn residency, University Medical Center, Jackson, 1976-80; elected by North Mississippi Medical Society.

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MAHER, JAMES W., Jackson. Born Coral Gables, FL, Sept. 27, 1948; M.D., University of Florida College of Medicine, Gainesville, 1974; interned University of Florida, Gainesville, one year; surgery residency, same, 1975-80; elected by Central Medical Society.

MARTIN, JAMES NELLO, Jackson. Born, Bethesda, MD, Feb. 14, 1947; M.D., University of North Carolina School of Medicine, Chapel Hill, 1973; interned and ob-gyn residency, North Carolina Memorial Hospital, Chapel Hill, 1973-77; fellowship in maternal and fetal medicine, Karolinska Hospital, Stockholm, Sweden and Parkland Memorial Hospital, Dallas, TX, 1977-79; elected by Central Medical Society.

MEADOR, GORDON HILL, JR., Tupelo. Born Jackson, MS, June 18, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1978; in-

terned and pediatric residency, University Medical Center, Jackson, 1978-81; elected by Northeast Mississippi Medical Society.

MOORE, DAVID BENJAMIN, JR., Tupelo. Born Jackson, MS, Jan. 24, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned, internal medicine, and pulmonary medicine fellowship, University Medical Center, Jackson, 1975-80; elected by Northeast Mississippi Medical Society.

NICHOLS, MICHAEL CURTISS, Greenwood. Born McAlester, OK, July 26, 1949; M.D., University of Oklahoma School of Medicine, Oklahoma City, 1974; interned San Bernardino Medical Center, San Bernardino, CA, one year; anesthesiology residency, UCLA, 1975-76; anesthesiology residency, Oklahoma University Medical School, Oklahoma City, 1976-77; elected by Delta Medical Society.

And there's more proof on the way!

1982 will see the completion of the Multiple Risk Factor Intervention Trial (MRFIT)—a six-year, 12,000-patient study assessing the factors that increase risk of cardiovascular disease. For the management of hypertension, the preferred Step-2 regimen in this study is reserpine-thiazide.

In 1978, in a preliminary report presented to the Epidemiology Section of the American Heart Association (Dallas, Nov 1978), after 12 months of the trial, fewer patients (5.3%) treated with reserpine suffered depression than even the untreated control group (7.7%)!

Please see references and brief summary of prescribing information on last pages of this advertisement.

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11/81

PARDUE, MARIANNA GUNTER, Jackson. Born Soso, MS, Oct. 5, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned, anatomical pathology and clinical pathology, University Medical Center and V. A. Hospital, Jackson, 1976-81; elected by Central Medical Society.

PINKSTON, WILLIAM CHAPPEL, Jackson. Born Oxford, MS, Dec. 15, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned, internal medicine and fellowship in pulmonary medicine, University Medical Center, Jackson, 1974-79; elected by Central Medical Society.

PRUETT, DAREL DEAN, Durant. Born Danville, KY, Sept. 25, 1949; D.O., Kansas City College of Osteopathy and Surgery, Kansas City, MO, 1980; interned Southeastern Medical Center, North Miami Beach, one year; elected by North Central Medical Society.

REIFF, TERRY DON, Durant. Born Independence, MO, Feb. 28, 1950; D.O., Kansas City College of Osteopathy and Surgery, Kansas City, Missouri, 1980; interned Charles Still Hospital, Jefferson City, MO, one year; elected by North Central Medical Society.

RHEA, CHARLES SAMUEL, JR., Columbus. Born Aberdeen, MS, Jan. 31, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned and orthopedic surgery residency, University Medical Center, Jackson, 1976-80; elected by Prairie Medical Society.

RUNNELS, RUDOLPH SCOTT, Magee. Born Mize, MS, Jan. 26, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and family practice residency, University Medical Center, Jackson, 1978-81; elected by Central Medical Society.

RUSHTON, FRED WALLACE, JR., Jackson. Born Corinth, MS, Dec. 21, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1971; interned, general surgery residency, peripheral vascular surgery fellowship, University Medical Center, Jackson, 1971-80; elected by Central Medical Society.

SHERWOOD, JULIA ANN, Jackson. Born Frankfort, Germany, Sept. 8, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and pediatric residency, University Medical

Salutensin® Salutensin-Demi™

(Hydroflumethiazide, Reserpine Antihypertensive Formulation)

Brief Summary of Prescribing Information (12) 10/27/78

For complete information consult Official Package Circular.

WARNING

This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

CONTRAINDICATIONS

Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

WARNINGS

Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or

without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients.

Use in Pregnancy

Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

PRECAUTIONS

Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia

(especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

Center, Jackson, 1978-81; elected by Central Medical Society.

STALLINGS, ALAN EUGENE, JR., Jackson. Born Little Rock, AR, May 14, 1946; M.D., University of Arkansas School of Medicine, Little Rock, 1972; interned and anesthesiology residency, University of Arkansas, Little Rock, 1972-74; anesthesiology residency, University Medical Center, Jackson, MS, 1974-75; fellowship, same, 1975-76; elected by Central Medical Society.

STRONG, ROBERT C., Jackson. Born Jackson, MS, July 25, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned and anesthesiology residency, University Medical Center, Jackson, 1976-77; anesthesiology residency, University of Texas, Galveston, TX, 1977-78; elected by Central Medical Society.

SUTTLE, SAMUEL KEITH, Louisville. Born Louisville, MS, July 17, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and family practice residency, University of Alabama, Montgomery, 1978-81; elected by East Mississippi Medical Society.

THOMPSON, WILL P., Yazoo City. Born Monroe, LA, July 16, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1970; interned University Medical Center, Jackson, one year; elected by Central Medical Society.

WARD, E. FRAZIER, Jackson. Born Crewe, VA, Aug. 17, 1939; M.D., University of Mississippi School of Medicine, Jackson, 1965; interned and orthopedic surgery residency, University Medical Center, Jackson, 1965-70; elected by Central Medical Society.

WEBBER, CHARLES MARTIN, Madison. Born Hattiesburg, MS, Dec. 25, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and family medicine residency, University Medical Center, Jackson, 1978-81; elected by Central Medical Society.

WHITEHEAD, WILLIAM ARTHUR, Hattiesburg. Born Natchitoches, LA, Dec. 26, 1942; M.D., Tulane University School of Medicine, New Orleans, 1968; interned and surgery residency, Vanderbilt, Nashville, TN, 1968-74; elected by South Mississippi Medical Society.

ADVERSE REACTIONS

Hydroflumethiazide

Skin-rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation.

Reserpine

Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares.

USUAL DOSE

1 tablet b.i.d.

SUPPLIED

Bottles of 100 and 1000 scored 50 mg. tablets.

References:

1. Propranolol in the treatment of essential hypertension. Veterans Administration Cooperative Study Group on Antihypertensive Agents. *JAMA* 237:2303-2310, 1977.
2. Five-year findings of the hypertension detection and follow-up program: I. Reduction in mortality of persons with high blood pressure, including mild hypertension. Hypertension Detection and Follow-up Program Cooperative Group. *JAMA* 242:2562-2571, 1979.
3. The 1980 Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med* 140:1280-1285, 1980.

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IN CONCLUSION

Only 17% of the adult population ever ask their physicians for generic prescriptions and only 20% ever request their pharmacists to fill prescriptions with generic products, according to a recent report. Only 25% of survey respondents age 65 or older reported purchasing generic drugs. Significantly greater numbers of respondents with the most education, highest incomes, and professional/managerial/owner occupations reported purchasing generics. College graduates led the subgroups in requesting generic products.

The American Hospital Association, disappointed in a January 8 federal court decision allowing continued imposition of expanded obligations on hospitals under the Hill-Burton program, is considering an appeal. In 1979 the Dept. of HHS (then HEW) changed the regulations, forcing 3600 hospitals under the program to provide higher levels of free care. AHA considers the increase - more than double the amount of the original grants - inappropriate, and says it causes a shift of the cost to already financially overburdened hospitals, other patients, and insurers.

Congress will be asked to enact legislation giving the government the power to crack down on health professionals who have defaulted on student loans, says HHS Secretary Richard Schweiker. The staff of the Senate Governmental Affairs Subcommittee reported that 50,000 health professionals, including more than 5,000 physicians, are seriously delinquent in repaying Health Professions Student Loans and Nursing Student Loans. As many as 30% of borrowers may be delinquent in repaying some \$20 million, Schweiker said.

A ten-year trend of increases in federal spending for health care came to a halt in 1981 with Reagan Administration victories in Congress, including: reductions in the federal contribution rate to Medicaid; decreases in Medicare benefits; reductions in federal aid for medical education; reductions in funding for health planning, PSROs and HMOs; termination of funds for eight hospitals and clinics of the U.S. Public Health Service; and termination of merchant seamen's rights to PHS hospital care. In 1982 the Administration will focus on pro-competition plans.

Charges for physicians' services rose at a rate of 1.1% in November, exceeding the rate of increase in the all-items (.3%) and all-services (.6%) components of the Consumer Price Index. During the month prices for prescription drugs rose .6%, costs for dental services went up .3%, and hospital room charges increased at a 2.4% rate. Over the 12-month period ending in November, physicians' fees increased at a rate of 12%. In that time the all-services component of the CPI went up 14.1% and the all-items component rose 9.6%. Hospital room charges rose 16.9%.

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Bactrim is useful for the following infections when due to susceptible strains of indicated organisms (see indications section in summary of product information):

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multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarthritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose[®] packages of 100; Prescription Paks of 20 and 28. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose[®] packages of 100; Prescription Paks of 40. Pediatric Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint).

Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonia. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS.

Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: General: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. Allergic reactions: Erythema



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Bactrim continues to demonstrate high clinical effectiveness in recurrent urinary tract infections. Bactrim reaches effective levels in urine, serum, and renal tissue¹...the trimethoprim component diffuses into vaginal secretions in bactericidal concentrations¹... and in the fecal flora, Bactrim effectively suppresses Enterobacteriaceae^{1,2} with little resulting emergence of resistant organisms.

1. Rubin RH, Swartz MN: *N Engl J Med* 303 426-432, Aug 21, 1980. 2. Data on file, Medical Department, Hoffmann-La Roche Inc.

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BactrimTM DS

160 mg trimethoprim and 800 mg sulfamethoxazole

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* due to susceptible strains of indicated organisms

Please see previous page for summary of product information.

March 1982

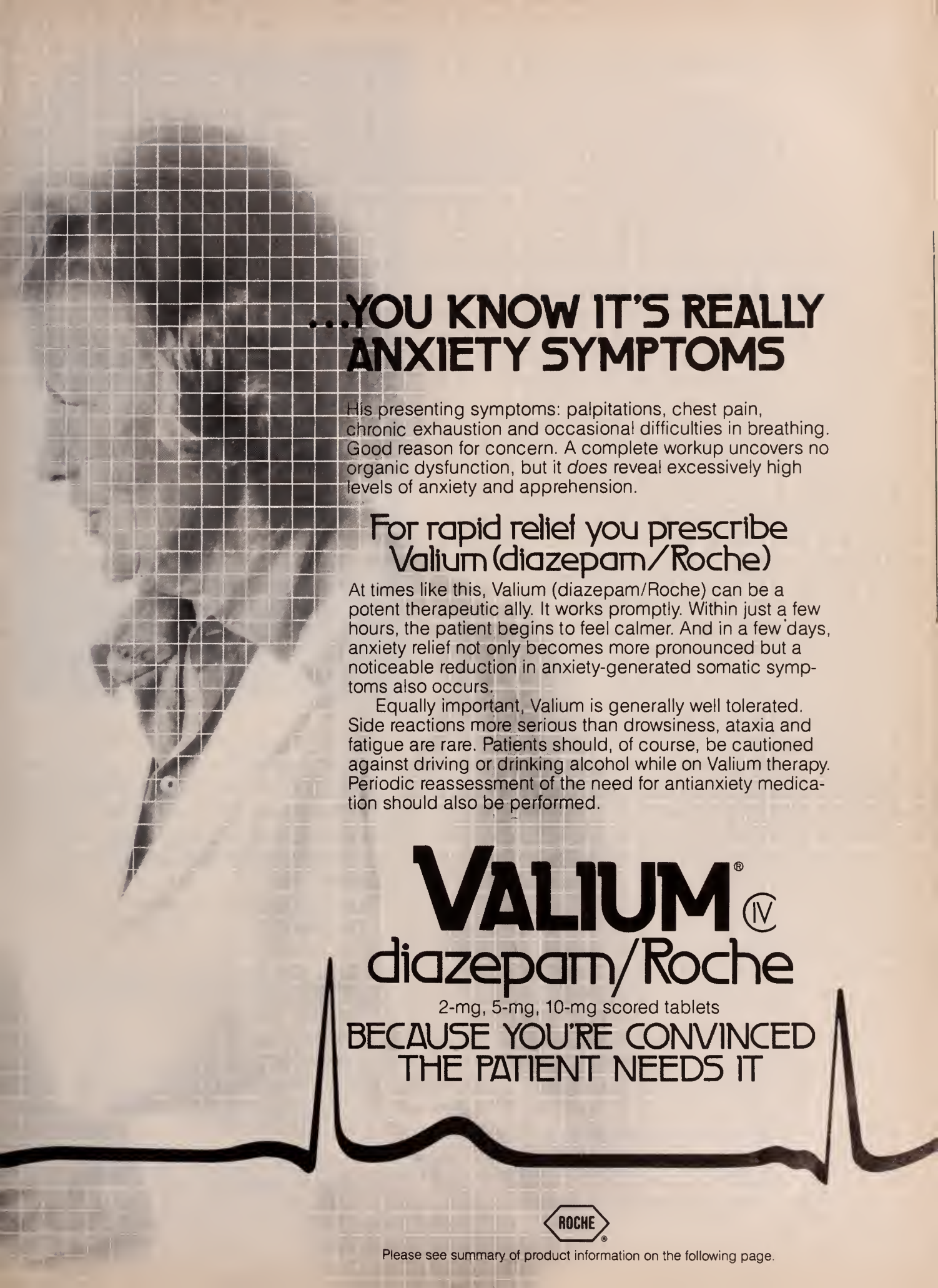
JOURNAL of the **MISSISSIPPI** State Medical Association



114th Annual Session — May 2-6, 1982 — Biloxi

**THE PATIENT THINKS
HE HAS HEART TROUBLE...**





...YOU KNOW IT'S REALLY ANXIETY SYMPTOMS

His presenting symptoms: palpitations, chest pain, chronic exhaustion and occasional difficulties in breathing. Good reason for concern. A complete workup uncovers no organic dysfunction, but it *does* reveal excessively high levels of anxiety and apprehension.

For rapid relief you prescribe Valium (diazepam/Roche)

At times like this, Valium (diazepam/Roche) can be a potent therapeutic ally. It works promptly. Within just a few hours, the patient begins to feel calmer. And in a few days, anxiety relief not only becomes more pronounced but a noticeable reduction in anxiety-generated somatic symptoms also occurs.

Equally important, Valium is generally well tolerated. Side reactions more serious than drowsiness, ataxia and fatigue are rare. Patients should, of course, be cautioned against driving or drinking alcohol while on Valium therapy. Periodic reassessment of the need for antianxiety medication should also be performed.

VALIUM[®] ^{IV}

diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

BECAUSE YOU'RE CONVINCED
THE PATIENT NEEDS IT



Please see summary of product information on the following page.

VALIUM® (diazepam/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy). The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

How Supplied: For oral administration, Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100* and 500,* Prescription Paks of 50, available in trays of 10.* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25,† and in boxes containing 10 strips of 10.*

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March 1982, Volume XXIII, Number 3

125th Anniversary Year

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INDICATIONS: *Therapeutically* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, scabies vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically*, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neo-



mycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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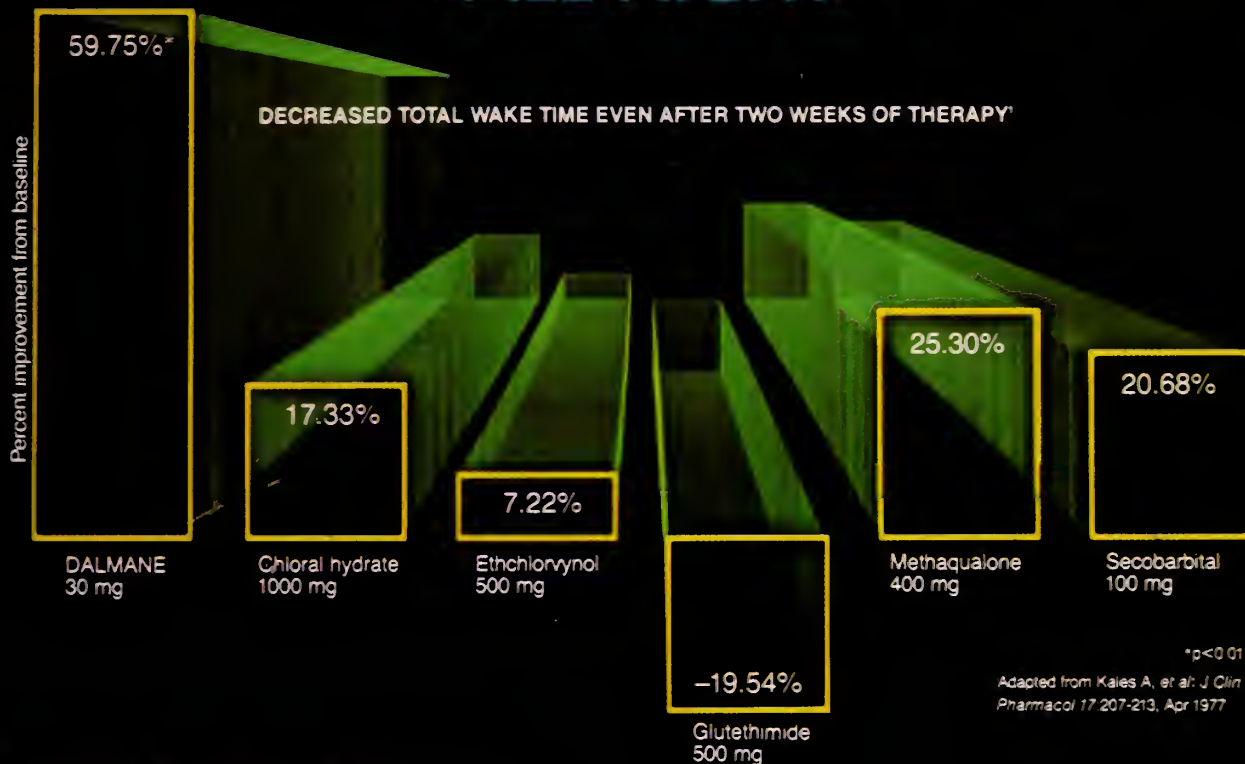
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WITH AN UNSURPASSED RECORD OF EFFICACY AND SAFETY

The efficacy of Dalmane (flurazepam HCl/Roche) has been documented in 185 studies involving 9141 patients suffering from one or more of the three major forms of insomnia—difficulty falling asleep, staying asleep and sleeping long enough.²

Relative safety was demonstrated in a large study of 2542 hospitalized medical patients. Only 3.1% of these patients reported adverse reactions—predominantly unwanted residual drowsiness. None of the reactions were considered serious by attending physicians.³

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Rapid sleep induction, within 17 minutes on average, sets the stage for insomnia relief. And, after discontinuation of Dalmane for periods ranging up to 14 nights, no worsening of sleep compared with baseline was observed.⁴

Should insomnia recur, the patient may require guidance in setting up a regular sleep program to help

provide the optimum environment for the onset of natural sleep. If hypnotic therapy is required, it should be given for the shortest time at the lowest effective dose to achieve the desired goal.

Consider other medications the patient may be taking (including alcoholic beverages) and be aware of possible drug interactions. Please note that patients should be treated for underlying physical or psychological factors before therapy with a sleep medication is undertaken.

DALMANE[®]
flurazepam HCl/Roche
**THE STANDARD OF HYPNOTIC EFFICACY
FROM THE LEADER IN SLEEP RESEARCH**



Please see reverse side for a summary
of product information.

EFFECTIVE ALL NIGHT



SLEEP-SPECIFIC **DALMANE**[®] _{IV} flurazepam HCl/Roche

One 15-mg capsule h.s.—recommended initial dosage for elderly or debilitated patients.

One 30-mg capsule h.s.—usual adult dosage (15 mg may suffice in some patients)

THE STANDARD FOR HYPNOTIC EFFICACY WITH IMPORTANT ADDED BENEFITS

- Well tolerated²
- No chemical interference with many commonly ordered laboratory tests, including triglycerides, uric acid, glucose, SGOT, alkaline phosphatase and total protein^{5,6} (See adverse reactions section of complete product information.)
- Compatible with chronic warfarin therapy: no unacceptable fluctuation in prothrombin time reported^{7,8}

UNLIKE NONSPECIFIC MEDICATIONS USED FOR SLEEP

Tricyclic antidepressants

- which are *not* sleep specific,⁹ yet are sometimes used in nondepressed patients for sleep
- which can cause transient insomnia in the elderly¹⁰
- which can require careful monitoring in cardiovascular patients¹⁰
- which have strong anticholinergic effects¹⁰

Antihistamines

- which are *not* reliable sleep-inducing agents¹¹
- which may produce stimulation instead¹¹
- which have anticholinergic effects¹¹

Major tranquilizers

- whose side effects may be troublesome for nonpsychotic patients¹²
- where tolerance for sedation appears rapidly¹²

Dalmane does not cause significant worsening of sleep beyond baseline levels upon discontinuation.⁴

References: 1. Kales A, et al. *J Clin Pharmacol* 17:207-213, Apr 1977 2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ 3. Greenblatt DJ, Allen MD, Shader RI. *Clin Pharmacol Ther* 21:355-361, Mar 1977 4. Kales A, et al. *Clin Pharmacol Ther* 18:356-363, Sep 1975 5. Moore JD, Weissman L. *J Clin Pharmacol* 16:241-244, May-Jun 1976 6. Spiegel HE. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ 7. Robinson DS, Amidon EL. Interaction of benzodiazepines with warfarin in man. In *The Benzodiazepines*, edited by Garattini S, Mussini E, Randall LO. New York, Raven Press, 1973, pp 641-646 8. Warfarin Study. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ 9. Baldessarini RJ. Drugs and the treatment of psychiatric disorders, chap 19. In Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6. New York, Macmillan Publishing Co Inc., 1980, pp 391-447 10. Cole JO, Davis JM. Antidepressant drugs, chap 31.2. In *Comprehensive Textbook of Psychiatry II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2. Baltimore: The Williams & Wilkins Company, vol 2, 1976, pp 1941-1956 11. Douglas WW. Histamine and 5-hydroxytryptamine (serotonin) and their antagonists, chap 26. In Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6. New York, Macmillan Publishing Co Inc., 1980, pp 609-646 12. Davis JM, Cole JO. Antipsychotic drugs, chap 31.1. In *Comprehensive Textbook of Psychiatry II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2. Baltimore: The Williams & Wilkins Company, vol 2, 1976, pp 1921-1940

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdose, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect.

Adults: 30 mg usual dosage; 15 mg may suffice in some patients. **Elderly or debilitated patients:** 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



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114th Annual Session

May 2-6, 1982

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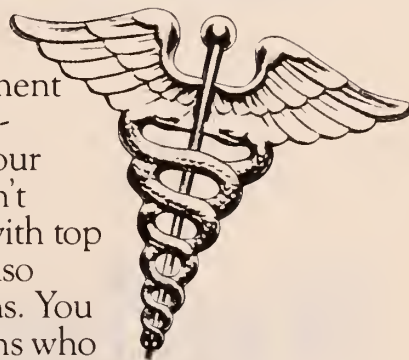
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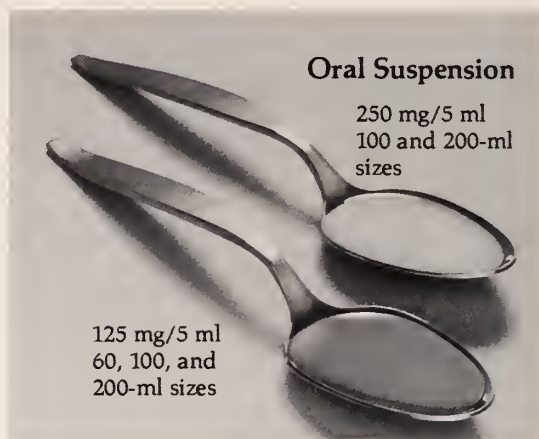
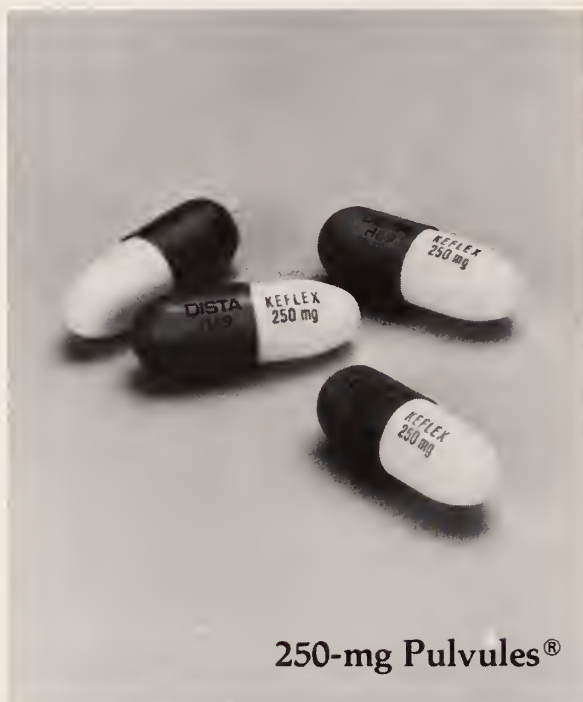
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NEWSLETTER

March 1982

Dear Doctor:

The upcoming 114th Annual Session of the Mississippi State Medical Association, May 2-6 in Biloxi, promises a varied scientific program. The preliminary scientific program is described elsewhere in this issue. Section officers are now making final arrangements and full details of the scientific program will be published in the April issue of Journal MSMA, including a complete list of topics and speakers and a list of scientific exhibits.

House of Delegates sessions are scheduled for the mornings of Monday, May 3 and Thursday, May 6. Reference committee meetings are set for Monday afternoon, May 3. Dr. Daniel T. Cloud, president of the American Medical Association, will address the House of Delegates at the Monday morning session.

Also on the annual session agenda is a financial planning workshop conducted by the AMA's Department of Practice Management. The workshop for physicians and spouses will be held Saturday, May 1. Physicians will also have the opportunity to attend a number of specialty society meetings during the week. But it won't be all work and no play, as there are many social, sports, and fellowship events.

The special events calendar includes the annual tennis and golf tournaments and a repeat of last year's popular attraction, the deep sea fishing rodeo. Space is limited for these activities, and pre-registration is recommended. Be sure to watch the MSMA "Blue Sheet" for information on early registration, and plan to make your reservation for these activities soon.

The MSMA Auxiliary will conduct its 59th Annual Session during the week. The program features a luncheon and fashion show and a makeup and skin care clinic. Auxiliary members will again host the Hospitality Center adjacent to MSMA registration and will staff the Boutique Booth, offering hand-made articles and crafts for sale, with proceeds going to the AMA-ERF.

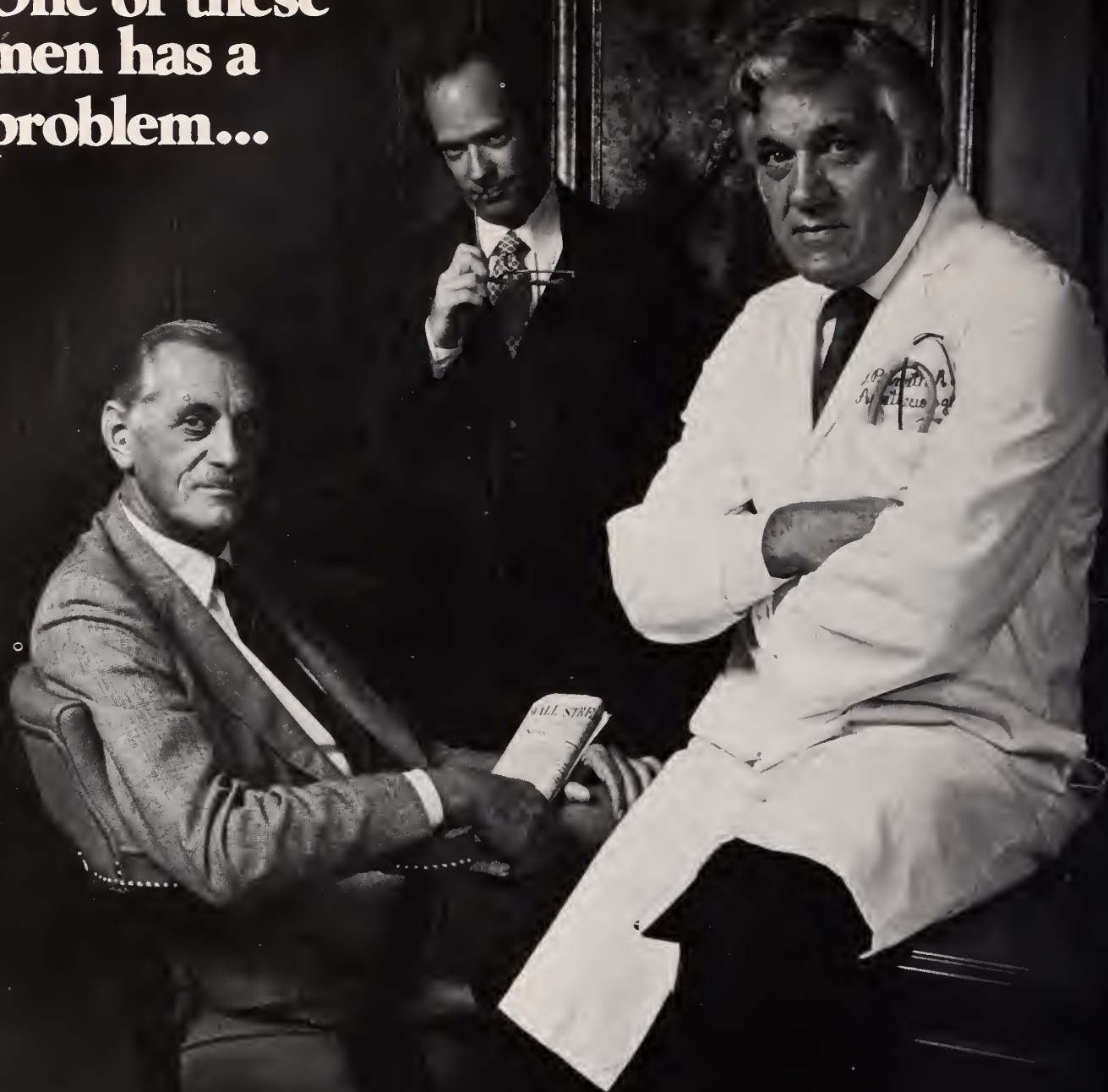
Other activities on the 114th Annual Session agenda are: an "early bird" reception sponsored by American Scientific Products; medical alumni parties; the annual MSMA president's reception; a membership banquet featuring Abigail Van Buren (Dear Abby) as guest speaker; and a special occasion on Wednesday night to celebrate the association's 125th anniversary.

Sincerely,



Patsy Silver
Managing Editor

One of these men has a problem...



and so do his family and colleagues.

There are special considerations in the treatment of professionals and executives who are impaired through dependency on drugs or alcohol: not because the patient or his addiction is different from others, but because of the strict sanctions imposed by the public and professional communities.

The A & D Center specializes in the treatment of the professional or executive who is chemically dependent. Treatment at the Center is designed to provide complete medical and counseling services, with care, dignity, and confidentiality for the patient. Family care and aftercare are emphasized, and specific plans are made for the re-entry process.

The A & D Center, located at the modern, 162-bed Doctors Hospital in Jackson, offers a 96-hour evaluation program, with the total inpatient treatment program extending for thirty days. For further information on the A & D Center, contact:



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(NIFEDIPINE) Capsules 10 mg

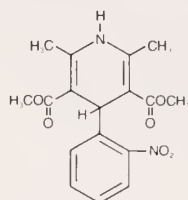
Please see PROCARDIA[®] prescribing information on next page.

PROCARDIA® CAPSULES

nifedipine

For Oral Use

DESCRIPTION: PROCARDIA (nifedipine) is an antianginal drug belonging to a new class of pharmacological agents, the calcium channel blockers. Nifedipine is 3,5-pyridinedicarboxylic acid, 1,4-dihydro-2,6-dimethyl-4-(2-nitrophenyl)-, dimethyl ester, C₁₇H₁₉N₂O₆, and has the structural formula:



Nifedipine is a yellow crystalline substance, practically insoluble in water but soluble in ethanol. It has a molecular weight of 346.3. PROCARDIA CAPSULES are formulated as soft gelatin capsules for oral administration each containing 10 mg nifedipine.

CLINICAL PHARMACOLOGY: PROCARDIA (nifedipine) is a calcium ion influx inhibitor (slow channel blocker or calcium ion antagonist) and inhibits the transmembrane influx of calcium ions into cardiac muscle and smooth muscle. The contractile processes of cardiac muscle and vascular smooth muscle are dependent upon the movement of extracellular calcium ions into these cells through specific ion channels. PROCARDIA selectively inhibits calcium ion influx across the cell membrane of cardiac muscle and vascular smooth muscle without changing serum calcium concentrations.

Mechanism of Action: The precise means by which this inhibition relieves angina has not been fully determined, but includes at least the following two mechanisms:

1) **Relaxation and prevention of coronary artery spasm:** PROCARDIA dilates the main coronary arteries and coronary arterioles, both in normal and ischemic regions, and is a potent inhibitor of coronary artery spasm, whether spontaneous or ergonovine-induced. This property increases myocardial oxygen delivery in patients with coronary artery spasm, and is responsible for the effectiveness of PROCARDIA in vasospastic (Prinzmetal's or variant) angina. Whether this effect plays any role in classical angina is not clear, but studies of exercise tolerance have not shown an increase in the maximum exercise rate-pressure product, a widely accepted measure of oxygen utilization. This suggests that, in general, relief of spasm or dilation of coronary arteries is not an important factor in classical angina.

2) **Reduction of oxygen utilization:** PROCARDIA regularly reduces arterial pressure at rest and at a given level of exercise by dilating peripheral arterioles and reducing the total peripheral resistance (afterload) against which the heart works. This unloading of the heart reduces myocardial energy consumption and oxygen requirements and probably accounts for the effectiveness of PROCARDIA in chronic stable angina.

Pharmacokinetics and Metabolism: PROCARDIA is rapidly and fully absorbed after oral administration. The drug is detectable in serum 10 minutes after oral administration, and peak blood levels occur in approximately 30 minutes. It is highly bound by serum proteins. PROCARDIA is extensively converted to inactive metabolites and approximately 80% of PROCARDIA and metabolites are eliminated via the kidneys. The half-life of nifedipine in plasma is approximately two hours. There is no information on the effects of renal or hepatic impairment on excretion or metabolism of PROCARDIA.

Hemodynamics: Like other slow channel blockers, PROCARDIA exerts a negative inotropic effect on isolated myocardial tissue. This is rarely, if ever, seen in intact animals or man, probably because of reflex responses to its vasodilating effects. In man, PROCARDIA causes decreased peripheral vascular resistance and a fall in systolic and diastolic pressure, usually modest (5–10 mm Hg systolic), but sometimes larger. There is usually a small increase in heart rate, a reflex response to vasodilation. Measurements of cardiac function in patients with normal ventricular function have generally found a small increase in cardiac index without major effects on ejection fraction, left ventricular end diastolic pressure (LVEDP) or volume (LVEDV). In patients with impaired ventricular function, most acute studies have shown some increase in ejection fraction and reduction in left ventricular filling pressure.

Electrophysiologic Effects: Although, like other members of its class, PROCARDIA decreases sinoatrial node function and atrioventricular conduction in isolated myocardial preparations, such effects have not been seen in studies in intact animals or in man. In formal electrophysiologic studies, predominantly in patients with normal conduction systems, PROCARDIA has had no tendency to prolong atrioventricular conduction, prolong sinus node recovery time, or slow sinus rate.

INDICATIONS AND USAGE: 1) **Vasospastic Angina:** PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

2) **Chronic Stable Angina (Classical Effort-Associated Angina):** PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta-blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Increased Angina/Beta Blocker Withdrawal: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand and resulting from increased heart rate alone.

Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients usually receiving a beta blocker have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event, as the unloading effect of PROCARDIA would be expected to be of less benefit to these patients, owing to their fixed impedance to flow across the aortic valve.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. See Warnings.

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to

diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents: See Indications and Warnings. Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Carcinogenesis, mutagenesis, impairment of fertility: Nifedipine was administered orally to rats for two years and was not shown to be carcinogenic. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose. *In vivo* mutagenicity studies were negative.

Pregnancy: Pregnancy category C. Nifedipine has been shown to be teratogenic in rats when given in doses 30 times the maximum recommended human dose. Nifedipine was embryotoxic (increased fetal resorptions, decreased fetal weight, increased stunted forms, increased fetal deaths, decreased neonatal survival) in rats, mice and rabbits at doses of from 3 to 10 times the maximum recommended human dose. In pregnant monkeys, doses 2/3 and twice the maximum recommended human dose resulted in small placentas and underdeveloped chorionic villi. In rats, doses three times the maximum human dose and higher caused prolongation of pregnancy. There are no adequate and well-controlled studies in pregnant women. PROCARDIA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

ADVERSE REACTIONS: In multiple-dose U.S. and foreign-controlled studies in which adverse reactions were reported spontaneously, adverse effects were frequent but generally not serious and rarely required discontinuation of therapy or dosage adjustment. Most were expected consequences of the vasodilator effects of PROCARDIA.

Adverse Effect	PROCARDIA (%) (N = 226)	Placebo (%) (N = 235)
Dizziness, light-headedness, giddiness	27	15
Flushing, heat sensation	25	8
Headache	23	20
Weakness	12	10
Nausea, heartburn	11	8
Muscle cramps, tremor	8	3
Peripheral edema	7	1
Nervousness, mood changes	7	4
Palpitation	7	5
Dyspnea, cough, wheezing	6	3
Nasal congestion, sore throat	6	8

There is also a large uncontrolled experience in over 2100 patients in the United States. Most of the patients had vasospastic or resistant angina pectoris, and about half had concomitant treatment with beta-adrenergic blocking agents. The most common adverse events were the same ones seen in the controlled trials, with dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

Several of these side effects appear to be dose related. Peripheral edema occurred in about one in 25 patients at doses less than 60 mg per day and in about one patient in eight at 120 mg per day or more. Transient hypotension, generally of mild to moderate severity and seldom requiring discontinuation of therapy, occurred in one of 50 patients at less than 60 mg per day and in one of 20 patients at 120 mg per day or more.

In addition, 2% or fewer of patients reported the following: **Respiratory:** Nasal and chest congestion, shortness of breath. **Gastrointestinal:** Diarrhea, constipation, cramps, flatulence. **Musculoskeletal:** Inflammation, joint stiffness, muscle cramps. **CNS:** Shakiness, nervousness, jitteriness, sleep disturbances, blurred vision, difficulties in balance. **Other:** Dermatitis, pruritus, urticaria, fever, sweating, chills, sexual difficulties.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

In a subgroup of over 1000 patients receiving PROCARDIA with concomitant beta blocker therapy, the pattern and incidence of adverse experiences was not different from that of the entire group of PROCARDIA treated patients (see Precautions).

In a subgroup of patients with a diagnosis of congestive heart failure as well as angina, dizziness or light-headedness, peripheral edema, headache or flushing each occurred in one in eight patients. Hypotension occurred in about one in 20 patients. Syncope occurred in approximately one patient in 250. Myocardial infarction or symptoms of congestive heart failure each occurred in about one patient in 15. Atrial or ventricular dysrhythmias each occurred in about one patient in 150.

Laboratory tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have already been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

OVERDOSAGE: Although there is no well documented experience with PROCARDIA overdosage, available data suggest that gross overdosage could result in excessive peripheral vasodilation with subsequent marked and probably prolonged systemic hypotension. Clinically significant hypotension due to PROCARDIA overdosage calls for active cardiovascular support including monitoring of cardiac and respiratory function, elevation of extremities, and attention to circulating fluid volume and urine output. A vasoconstrictor (such as norepinephrine) may be helpful in restoring vascular tone and blood pressure, provided that there is no contraindication to its use. Clearance of PROCARDIA would be expected to be prolonged in patients with impaired liver function. Since PROCARDIA is highly protein-bound, dialysis is not likely to be of benefit.

DOSE AND ADMINISTRATION: The dosage of PROCARDIA needed to suppress angina and that can be tolerated by the patient must be established by titration. Excessive doses can result in hypotension.

The starting dose is one 10 mg capsule, swallowed whole, 3 times a day. The usual effective dose range is 10–20 mg three times daily. Some patients, especially those with evidence of coronary artery spasm, respond only to higher doses, more frequent administration, or both. In such patients, doses of 20–30 mg three or four times daily may be effective. Doses above 120 mg daily are rarely necessary. More than 180 mg per day is not recommended.

In most cases, PROCARDIA titration should proceed over a 7–14 day period so that the physician can assess the response to each dose level and monitor the blood pressure before proceeding to higher doses.

If symptoms so warrant, titration may proceed more rapidly provided that the patient is assessed frequently. Based on the patient's physical activity level, attack frequency, and sublingual nitroglycerin consumption, the dose of PROCARDIA may be increased from 10 mg t.i.d. to 20 mg t.i.d. and then to 30 mg t.i.d. over a three-day period.

In hospitalized patients under close observation, the dose may be increased in 10 mg increments over four to six-hour periods as required to control pain and arrhythmias due to ischemia. A single dose should rarely exceed 30 mg.

No "rebound effect" has been observed upon discontinuation of PROCARDIA. However, if discontinuation of PROCARDIA is necessary, sound clinical practice suggests that the dosage should be decreased gradually with close physician supervision.

Co-Administration with Other Antianginal Drugs: Sublingual nitroglycerin may be taken as required for the control of acute manifestations of angina, particularly during PROCARDIA titration. See Precautions, Drug Interactions for information on co-administration of PROCARDIA with beta blockers or long-acting nitrates.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA Capsule contains 10 mg of nifedipine. PROCARDIA Capsules are supplied in amber glass bottles of 100 capsules (NDC 0069-2600-66). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

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Issued January 1982



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As of January 1, 1982, a number of changes have been made in the Federal regulations governing IRA (Individual Retirement Account) and Keogh Tax-Deferred Retirement Savings Plans. The major changes that would be of primary interest to the medical profession are summarized below:

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For an individual Wage Earner	Up to \$2,000.
For a Wage Earner with Non-Working Spouse	Up to \$2,250.
For Working Married Couples with each having an individual IRA	Up to \$2,000 each (for a total of \$4,000 per couple).
For a Keogh Plan	Up to \$15,000.
For a SEP (Simplified Employee Pension)	Up to \$15,000.

Note: If you have a Keogh Plan, you can now establish an IRA.

ALSO, DEPOSIT GUARANTY IS NOW PAYING MONEY MARKET INTEREST RATES ON ALL DEPOSITS TO NEW AND EXISTING IRA AND KEOGH ACCOUNTS...REGARDLESS OF THE AMOUNT OF DEPOSIT.

Experienced personnel in any office of Deposit Guaranty can give you complete information on the new IRA and Keogh Tax-Shelter and Tax-Deferred Savings Benefits and help you set up a plan that will be best for you, as an individual, or for your organization as a whole.



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Federal regulations require a substantial interest penalty for early withdrawal of funds from an IRA. Also, the Internal Revenue Service imposes a 10% penalty on the amount withdrawn and the amount withdrawn must be included in taxable income.

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DATELINE

Hazardous Waste Project Opposed

Natchez, MS - The Homochitto Valley Medical Society opposes the proposed hazardous waste injection wells in Adams County because of potential contamination of the water supply and possible health hazard to the population. The society has petitioned the board of supervisors and the Natchez-Adams Chamber of Commerce to rescind their previous endorsement of the project proposed by Conservation Services, Inc., which claims the injection wells are safe disposal methods.

Leadership Conference This Month in Jackson

Jackson, MS - MSMA's Leadership Conference later this month will feature an address by Congressman G. V. (Sonny) Montgomery, who will discuss "Reaganomics: The New Federalism." Among other topics on the program are: health legislation, federal-state programs, third-party programs, and a malpractice update. If you failed to get a brochure with details of the March 27 conference, please contact the MSMA headquarters office for information.

Community Cost Containment Projects

Chicago, IL - A \$16.2 million program to help communities set up health care cost containment projects is being co-sponsored by the Robert Wood Johnson Foundation, American Hospital Association and Blue Cross and Blue Shield Associations. A purpose of the program "is to demonstrate the ability of hospitals, health insurers, and the medical profession to work together with business, labor and others to carry out major broad-based local projects."

Conference Studies Sodium Labeling

Chicago, IL - Various perspectives on sodium labeling will be discussed this month at an AMA conference which will bring together representatives of health organizations, the food industry and federal agencies. Health implications of sodium labeling will be discussed, along with various organizations' positions on labeling, technical problems, use of appropriate substitute ingredients, and cost effective ways to accomplish labeling.

Magazines As Information Sources

New York, NY - Popular magazines are a major source of nutrition information for many patients. According to a study of 19 popular magazines by the American Council of Science and Health, only five received good marks for accuracy of information: 50-Plus, Parents, Redbook, Reader's Digest and Good Housekeeping. Others were found to be either inconsistent or unreliable. Survey considered whether information was scientifically sound, credentials of supposed experts, etc.

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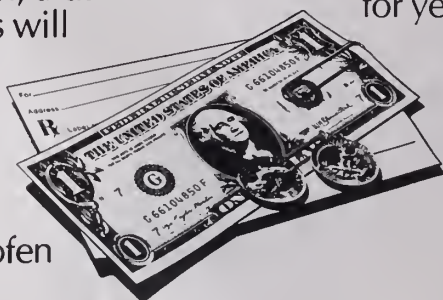
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*Data on file.

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INDICATIONS AND USAGE: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in the long-term management of these diseases. Safety and effectiveness have not been established for Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see WARNINGS).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally; however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: Coumarin-type anticoagulants. The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin. Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS

Incidence greater than 1%

Gastrointestinal: The most frequent adverse reaction is gastrointestinal (4% to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme. **Special Senses:** amblyopia (see PRECAUTIONS). **Hematologic:** leukopenia, decreased hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities. **Dermatologic:** alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** hemolytic anemia, thrombocytopenia, granulocytopenia bleeding episodes. **Allergic:** fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** gynecomastia, hypoglycemia. **Cardiovascular:** arrhythmias (Sinus tachycardia, bradycardia, and palpitations). **Renal:** decreased creatinine clearance, polyuria, azotemia.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

DOSAGE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flareups of chronic disease: Suggested dosage 400 mg t.i.d. or q.i.d.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain. Do not exceed 2,400 mg per day.

CAUTION: Federal law prohibits dispensing without prescription.

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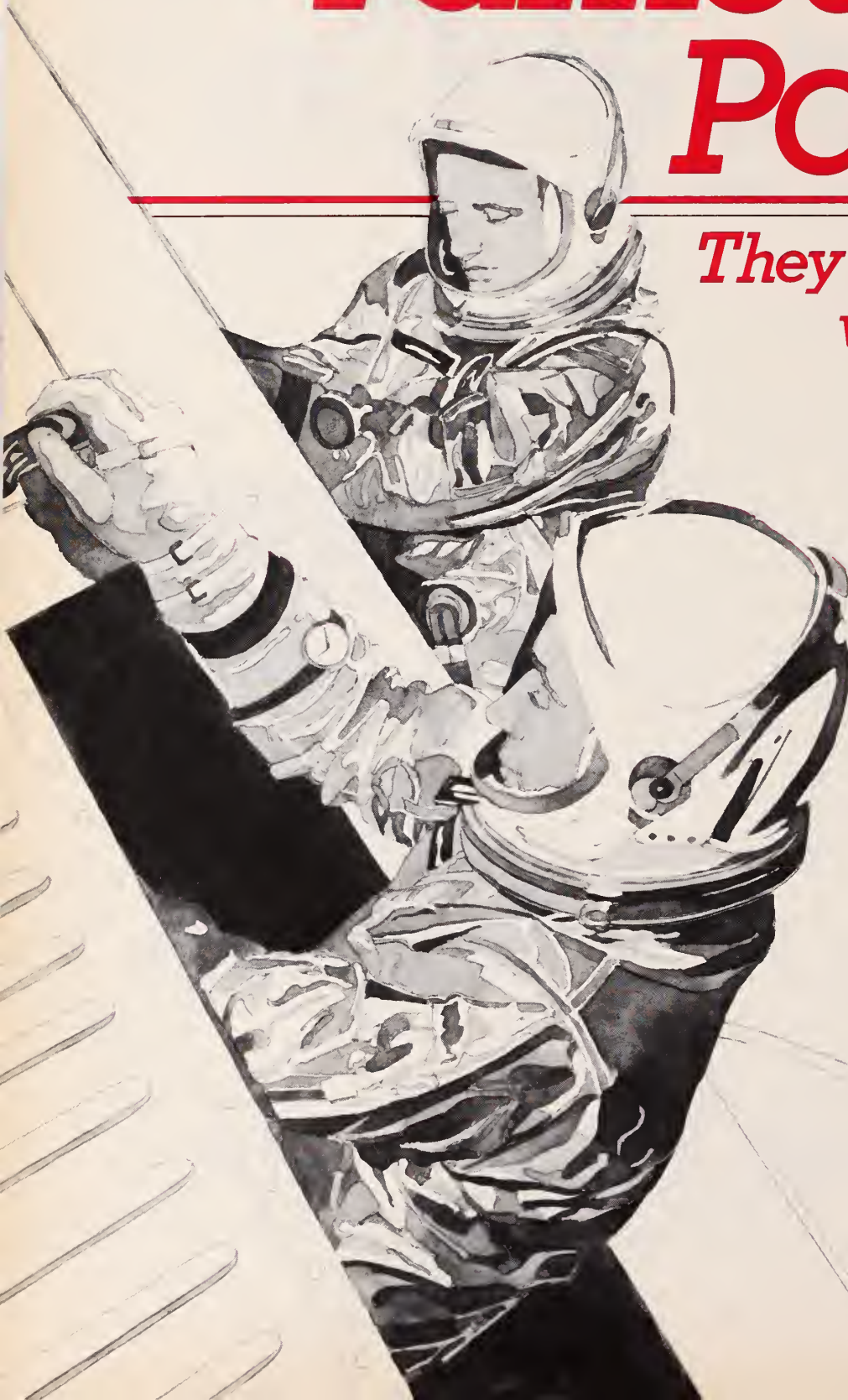
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* Meeting of Am Soc Colon/Rectal Surgeons, May 1980.

** Based on total prescriptions filled for hemorrhoidal preparations during the first three quarters of 1981. The National Prescription Audit, IMS America Ltd, Sept 1981.

* 1981 data from leading marketing research organization.

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Indications and Usage:

Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in external and internal hemorrhoids, proctitis, papillitis, cryptitis, and fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol[®] Suppositories or Ointment.

CONTRAINDICATIONS

Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

WARNINGS

The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

PRECAUTIONS

General

Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.

Pregnancy

See "WARNINGS"

Pediatric Use

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

DOSSAGE AND ADMINISTRATION

Anusol-HC Suppositories—Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

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ORIGINAL PAPERS

Radiologic Seminar CCXX: Use of CT Body Scanning For Colon Cancer Follow-up

PHILIP E. CRANSTON, M.D. and
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Jackson, Mississippi

CARCINOMA OF THE LARGE BOWEL remains the most malignant intestinal tumor among both men and women. The five-year survival rate has not changed significantly in the last two decades. Because of a significant rate of recurrence after surgery, aftercare becomes highly important for early detection and treatment of recurrence.

Abdominal CT scanning has now been shown to be an excellent diagnostic modality for follow-up of colon cancer patients, particularly those after abdominoperineal resection.^{1, 2, 3} Recurrence of colon cancer frequently manifests itself as a focal mass at the primary site or distal to it, pelvic and abdominal adenopathy, or as lung, bone or brain metastasis. Bone metastases are particularly noted around the pelvis.²

The following cases illustrate the applications of abdominal CT scanning in the most frequent types of colon cancer recurrences and metastases.

Case Reports

Case 1 demonstrates typical liver metastatic lesions (see Figure 1). The patient had metastatic liver disease at the time of initial surgery. Abdominal CT scan demonstrated hepatomegaly with multiple, hypodense defects involving the liver.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, University of Mississippi
Medical Center, Jackson, MS.

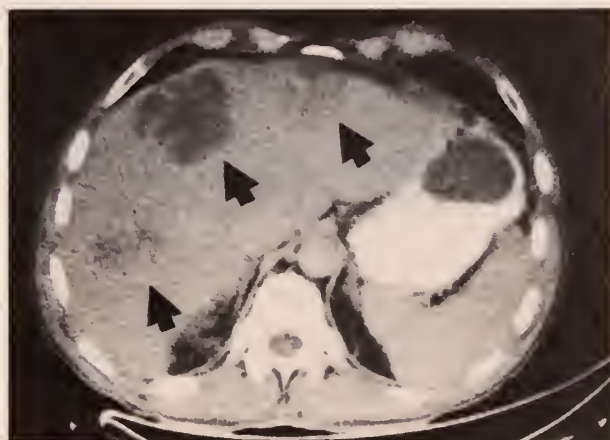


Figure 1. Multiple lucent metastatic colon lesions are indicated by the arrows.

Case 2 demonstrates the appearance of local recurrence as well as large metastatic liver lesions (see Figure 2A, 2B). This patient had resection of the initial tumor in the sigmoid colon. Later, he developed a pararectal mass along with metastatic lesions in the liver.

Case 3 demonstrates the recurrence of a large pelvic mass with destruction of the sacrum (see Figure 3A). The radionuclide bone scan could not show these findings due to radioactivity in the bladder shielding the tumor (see Figure 3B). This patient had

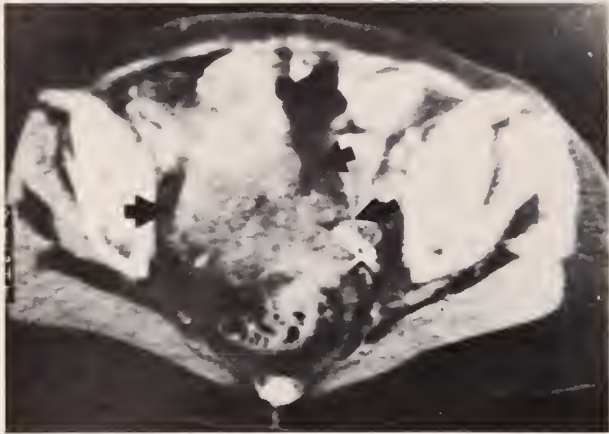


Figure 2A. A soft tissue pelvic recurrence is pointed out by the arrows in front of the rectum.

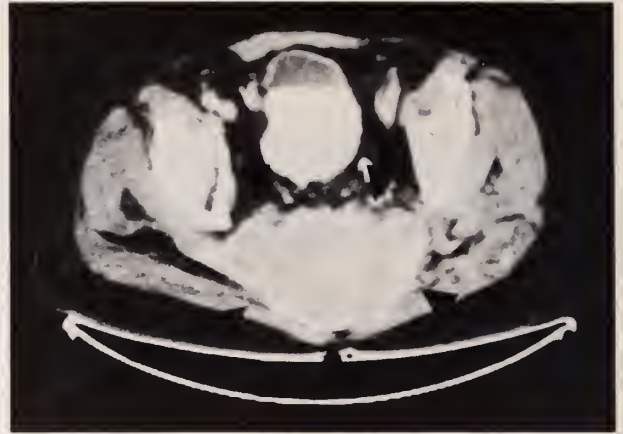


Figure 3A. A large tumor recurrence is shown (outlined by the arrows) which has replaced the sacrum.

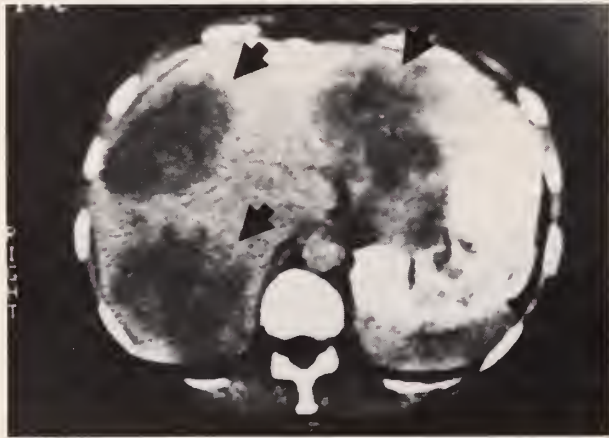


Figure 2B. Large liver lesions are demonstrated.



Figure 3B. Tumor activity is obscured by urinary bladder activity on the radionuclide bone scan.

a rectal cancer resected earlier and was complaining of a dull, aching sacral pain.

Case 4 demonstrates considerable retroperitoneal adenopathy secondary to recurrent colon cancer (see Figure 4). Several months following resection of a hepatic flexure cancer, the patient was doing poorly. An upper G.I. series suggested a retrogastric mass, verified by CT scanning.

Discussion

Abdominal CT scanning has several applications in patients with colon cancer. Although large colon carcinomas can be diagnosed by CT scans, barium enema is the procedure of choice in detection of colon cancers. Preoperatively, scans are used for

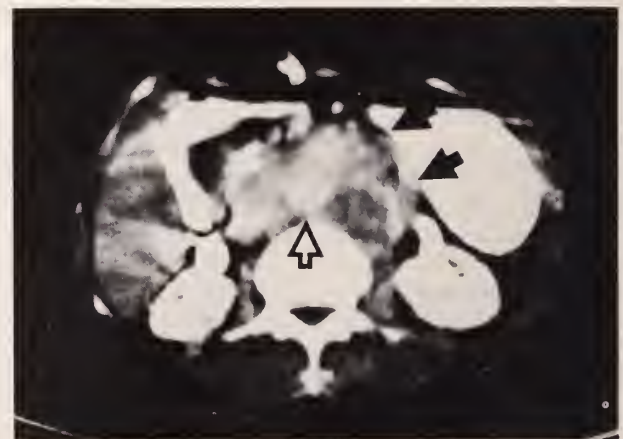


Figure 4. Massive retroperitoneal adenopathy is outlined by the closed arrows. The stomach is displaced anteriorly. The encircled aorta is noted by the open arrow.

staging. Distant spread in the form of metastases as well as local, contiguous spread outside the bowel wall can be confidently detected. Postoperative CT scans are indicated for several reasons. A base-line scan is useful for detection of growth of a tumor if a partially resected tumor is left in the abdomen. An accurate assessment of residual or recurrent disease can be made after radiation or chemotherapy. A postoperative scan can be used for radiation portal planning. Periodic follow-up scans can also be used to detect early recurrence that is clinically not evident. Clinically suspected recurrence can be corroborated with CT scans.

Scans are also used to detect or confirm metastasis to liver, lung, abdominal lymph nodes, spine and pelvis. Accurate biopsy of primary or metastatic disease can be done with CT guidance. CT scanning can also aid in detection and treatment of pathologic conditions, such as abscesses, that are associated with colon carcinomas.

Complementary to clinical assessment, laboratory and other diagnostic tests such as radionuclide scans, ultrasonography and plain film x-ray studies are used in the follow-up of patients with colon cancers. As a single diagnostic test, CT scan of the abdomen may be more advantageous than any other test. While a radionuclide bone scan is a sensitive test to evaluate the whole skeleton for metastases, abdominal CT scan can evaluate bones as well as soft tissue and various intraabdominal organs such as liver, spleen, adrenal glands, etc. One can speculate obviation of radionuclide liver-spleen scans in these patients if liver metastases from colon carcino-

mas are assumed to be all focal and not infiltrating lesions. Conventional x-ray studies can only provide limited evaluation of head, chest and abdomen in these cases. Although barium enema is an important test for follow-up of patients with colon cancers, significant extraluminal disease can exist despite a normal study. Furthermore, following an abdominoperineal resection, a lower colon may not be available for study.³ Ultrasonography can be used for evaluation of liver and upper abdomen but may preclude satisfactory examination of the rest of the abdomen due to bowel gas.

In conclusion, body CT scanning (abdomen, pelvis and chest) has been shown to be extremely useful in patients with colon cancers, both for initial as well as follow-up studies and especially in those patients whose primary sites were in the pelvis. For maximum information, proper attention to technique should be paid.¹ CT may have the potential to provide considerable improvement in palliation of recurrent colon cancers and improve survival rates in the future.

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References

1. Mayes, B. G. and Zornoza, J.: Computed tomography of colon carcinoma. *AJR* 135:43-46, July, 1980.
2. Ellert, J. and Kreel, L.: The value of CT in malignant colonic tumors. *CT: The Journal of Computed Tomography* 4; No. 3:225-240, September, 1980.
3. Von Frommhold, W. and Hübener, K.-H.: The role of computerized tomography in the after care of patients suffering from a carcinoma of the rectum. *Computerized Tomography* 5; No. 2:161-168, 1981.

Cardiac Rehabilitation: Three Years Later

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THE CHANGING ROLE and value of cardiac rehabilitation for the patient with post-myocardial infarction, post aorto-coronary artery bypass surgery, and high risk for coronary artery disease were described in an earlier issue of this journal.¹ Data collected on the levels of fitness, both physical and psychological, were presented in that study after one year of operation of the Cardiac Rehabilitation Program at the Mississippi Methodist Hospital and Rehabilitation Center. A supervised team approach was utilized as an acceptable alternative to what once demanded extensive physician time and specialized training. Temporary credence to that view was reported in the preliminary findings of 37 patients.

This follow-up study extends the original patient group of 37 to include all new patients who were enrolled in the Cardiac Rehabilitation Program at the Mississippi Methodist Hospital and Rehabilitation Center during the second and third years of operation. Period of time covered in the study is from January 1, 1978 through December 31, 1980.

As of December 31, 1980, 222 patients had enrolled in the cardiac rehabilitation program which consisted of a one-hour closely supervised and monitored exercise session and a one-hour education session held three times weekly for approximately eight weeks. One hundred seventy patients (77%) completed the program. There were 30 dropouts (13%). Seven of these dropped out because of competing work schedules. Ten dropped out due to long traveling distances, some of which exceeded 300 miles round trip. Three dropped out fearing that completion of the program would jeopardize their disability status. Other reasons given were lack of

time for program, hurricane damaging living quarters, homesickness, and not wanting to exercise. There were 16 terminations (7%) for medical reasons. Three developed gallbladder problems which required surgery. One was injured in a motor vehicle accident. One had frequent episodes of syncope, while yet another had frequently recurring epileptic seizures. Six patients (3%) were still actively participating when data were collected.

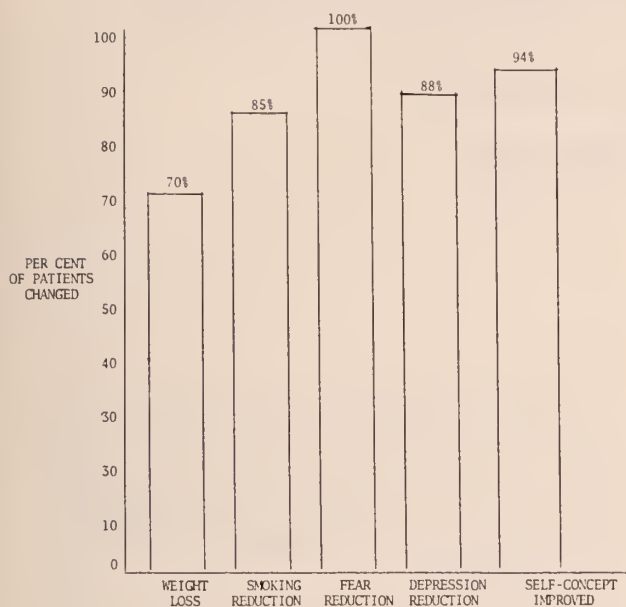
Each patient was assessed with pretest, posttest, and follow-up behavioral measures in areas of weight, smoking, fear, depression, and self-concept. Individual as well as collective data were compiled for each respective variable. Assessment of metabolic equivalent (MET) of exercise was made at the beginning and end of the program for each individual patient.

Data indicated that of those patients (97%) who needed to lose weight, 70% successfully lost weight, 5% remained static, 14% gained weight, and 11% lost but regained the loss. The average weight loss per patient was 8.6 pounds with a range of one to 50 pounds. This loss was maintained some months later. However, several patients who lost weight at the onset and during the program did not maintain the loss at the time of follow-up.

There were 104 smokers during the three years of the program. These data indicated 45% of the smokers quit while 40% cut down their cigarette consumption. There was a 15% failure rate. The average reduction per patient was 24.7 cigarettes per day with a daily range from one to 80 cigarettes.

Every patient entered the program with some degree of fear. In this area, data showed that 100% of the patients were successful in reducing this behavior. The average numerical points decrease per patient, as measured on the Wolpe-Lang Fear Survey Schedule, was 34.3. This significant finding

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appeared more remarkable when considering the fact that 25% of the patients were judged normal, ie, average in fear behavior at time of admission into the program. Results indicated these patients also showed a marked decrease in level of fear behavior of 10.8 points per patient.

Data compiled from the findings on depression showed that 88% of the patients were able to reduce this behavior. The average numerical decrease per patient was 10.5 as measured on the Zung Depression Scale. The patients (12%) who failed to show a reduction in depression scored in the normal, non-psychopathology range at the time of admission to the program.

Self-concept findings indicated 94% of the patients successfully improved their self-image. There was a very positive improvement in feelings of self-worth, confidence, usefulness, and outlook on life. All these changes were sustained at time of follow-up. Those patients (6%) who did not improve in area of self-concept rated "excellent" on all measures at time of their admission to the program. There were no deficit areas shown in need of improvement at time of their initial assessment.

When the patients began the cardiac rehabilitation

program, the estimated level of their activity was approximately 1.5 to 2.5 METS. At completion of eight weeks of controlled and monitored exercise regime, many of the patients were functioning at or above the 6.0 MET level. Those who failed to achieve the 6.0 MET level were incapacitated with neuromuscular disease or had other complications which prevented their participation at a 100% involvement rate.

Compliance to the program in general, and to the exercise prescription specifically, was excellent. Of the 222 patients enrolled in the program, 170 (77%) completed the 24 sessions, 6 (3%) were actively participating at time of data collection, 16 (7%) were terminated for various medical reasons, and 30 (13%) dropped out. The compliance rate was 80% overall. When excepting medical terminations, the compliance was an even more favorable 87%.

Data collected on these behavioral variables reinforce the previously stated preliminary data indicating that the multifaceted cardiac rehabilitation team program appears to be an established, logical, feasible, and successful alternative in the treatment of many types of cardiovascular disease.

Summary

The purpose of this paper was to provide follow-up data on the three year operation of the outpatient cardiac rehabilitation program at the Mississippi Methodist Hospital and Rehabilitation Center from the inception in January, 1978 through December 31, 1980. The program consisted of a one-hour exercise session along with a one-hour education session three times weekly for approximately eight weeks. The cardiac program utilized a multidisciplinary team approach to rehabilitation of the individual. The group education sessions included individual sessions on each of the risk factors of coronary artery disease. Patients who received benefits from the program were in categories of post-myocardial infarction, post aorto-coronary artery bypass surgery, as well as those persons considered high risk for coronary artery disease. Findings of the data collected on the patients enrolled in the program showed weight reduction in 70%, smoking reduction in 85%, reduced fear in 100%, reduced depression in 88%, improved self-concept in 94%, and an average increase in the physical activity level from 1 to 10 METs.

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References

1. Wofford, J. D., Wofford, E., Beissel, G. F. and Brumfield, J.: Cardiac Rehabilitation. J. Miss. State Med. Asso. 20:23-27, Feb., 1979.

The Biochemistry of Inflammation: Rheumatoid Arthritis and Anti-Inflammatory Drugs

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New York, New York

RHEUMATOID ARTHRITIS is characterized by joint inflammation: heat, pain, redness, swelling and finally, loss of function. These cardinal signs of inflammation are usually launched in tissues by the interaction of cells of the host with invading bacteria or viruses, or to irritants the nature of which remain unknown. The latter, unfortunately, describes the situation in rheumatoid arthritis.

Consequently rheumatic diseases may be considered diseases of sterile inflammation launched by an unknown invader or a genetic flaw.

An analysis, therefore, of inflammation and its mediators should help us to understand how anti-inflammatory agents, such as the nonsteroidals, act. Although there is probably no such thing as a general "inflammatory process" there can be discerned a pattern common to all forms of inflammation: a microscopic battle plan. This adaptive warfare and the resultant battlefield are referred to as inflammation. If, in rheumatoid arthritis, we are faced with aroused tissues in the absence of exogenous irritants, we can only limit the battle area. Unlike the situation in infectious diseases (where we can eliminate the invading organisms by antibiotics), in rheumatoid arthritis we are left with a choice between completely masking the defensive response and leaving the host defenseless, or of permitting inflammation to proceed and limiting its consequences. Nonsteroidal anti-inflammatory agents, because they only *partially* block inflammation, are at present a reasonable compromise: they do not disarm the defender, but deprive him of the means for self-injury.

The James Grant Thompson Memorial Lecture read before the 113th Annual Session of the Mississippi State Medical Association, April 29, 1981, Biloxi, MS.

From the Division of Rheumatology, Department of Medicine, New York University Medical Center, 550 First Avenue, New York, NY.

The James Grant Thompson Memorial Lecture was established by the family of the late Dr. James Grant Thompson — civic leader, pioneer in the field of dermatology, and president of the Mississippi State Medical Association.

Our current views of inflammation have resulted in an elaborate scheme of interacting events. These events involve a number of chemical mediators, cells of the reticuloendothelial system, and proteins of plasma. Some of these proteins are involved in the coagulation of blood whereas others are part of the complement or kinin systems. Each of the proteins interacts with yet other mediators released by cells, such as the prostaglandins. The total response of inflammation can be launched by a wide variety of stimuli such as physical injury, immunologic reactions, or the deposition of crystals (such as monosodium urate in gout) and even infection.

Mediators of Inflammation

Those mediators of inflammation which appear to be most subject to the action of nonsteroidal anti-inflammatory agents are histamine, serotonin, kinins, and above all, prostaglandins.

Histamine, which was previously considered to be the major chemical mediator of the inflammatory response, is now known to be only active during the earliest phases of inflammation. Stored in mast cells, histamine is released following almost all tissue injury, especially after specific antigen-antibody reactions. It causes dilation of blood vessels and permeability of the blood vessel wall. This is thought to be due to endothelial cells which line

blood vessels; in guinea pig skin, the action of histamine can be significantly diminished by salicylates. Histamine can also produce constriction of the bronchi of guinea pig lung, but this action is *not* inhibited by anti-inflammatory agents. Thus it is clear that inhibiting the effects of histamine is not the major mode of action of non-steroidal anti-inflammatory drugs.

Similarly, *serotonin* (5-hydroxytryptamine) is also found in inflammatory exudates, and can produce effects on the blood vessels and their permeability in both animals and man. However, serotonin-induced blood vessel changes are not antagonized effectively by aspirin, although some non-steroidal anti-inflammatory drugs have a modest inhibitory effect upon vascular permeability induced by serotonin. Perhaps the best evidence that non-steroidal anti-inflammatory drugs do not work by inhibiting serotonin release is that pure serotonin antagonists are not good anti-inflammatory agents.

Another group of mediators of inflammation which have undergone scrutiny as targets for non-steroidal anti-inflammatory agents are the *kinins*. Kinins are short chain peptides (nine or ten amino acids) which release from inactive plasma precursors after a variety of stimuli which include immune reactions, physical irritation, and constituents of white cells. Although they are not active for long (since they are broken down by ubiquitous enzymes present in all tissues), the kinins can produce all of the cardinal signs of inflammation, as well as the contraction of smooth muscle. Moreover, the kinins can interact with the complement cascade. Activation of the kinin system is inhibited by aspirin and by glucocorticoids. However, nonsteroidal anti-inflammatory agents do not completely inhibit kinin release or generation. Although recent data demonstrate that the kinins can mimic many of the signs of naturally occurring inflammation, these compounds, acting alone, by no means account for all of the features of natural inflammation.

Lysosomal enzymes and *complement* are probably the most significant mediators of tissue injury released in the course of inflammatory arthritis. White cells, when stimulated to phagocytose particles such as immune complexes (aggregated IgG and rheumatoid factor), release a series of lytic ferments (lysosomal enzymes). These lysosomal enzymes include proteases capable of cleaving all of the connective tissue substrates present in cartilage or surrounding tissues. The enzymes are capable of degrading collagen, elastin, and the proteoglycans which constitute the bulk of cartilage. Thus release of enzymes from lysosomes of polymorphonuclear leukocytes

and of the cells of the joint themselves, appears to be responsible for irreversible connective tissue injury: crippling arthritis. There is no evidence available at the present time that nonsteroidal anti-inflammatory drugs influence the release of these lytic ferments from the cells where they have previously been sequestered. Nor do nonsteroidal anti-inflammatory compounds inhibit the action of the complement system. This system of proteins, present in inactive form in the circulation (C1-C9), is activated to launch a membrane attack (C5b-C9) upon invading microorganisms or the host cells themselves. Usually the complement system is activated by immunologic reactions or by the introduction of foreign materials, but its mechanism of activation can also be bypassed when enzymes are released from white cells or connective tissue cells.

Mechanism of Inflammation in Rheumatoid Arthritis

As described above, the main feature of rheumatoid arthritis is the appearance in the circulation or synovial fluid of rheumatoid factor. This is an antibody, elaborated by the patient with rheumatoid arthritis against others of his own antibody molecules and may be considered simply as "altered IgG." Such antibody molecules become altered when they meet an antigen, such as bacteria or virus; we do not yet know the nature of such antigens in rheumatoid arthritis. Indeed, we are not certain whether IgG molecules become altered as a result of meeting such an antigen or because of some heritable flaw. These unknowns are, of course, the major questions in the etiology of rheumatoid arthritis. Once, however, rheumatoid factor is generated by the patient with rheumatoid arthritis, the remainder of the sequence has been rather well analyzed. The interaction of rheumatoid factor with altered IgG leads to the formation of immune complexes. These immune complexes lead to chemotaxis, namely the influx of inflammatory cells into the inflamed synovium; at the same time these complexes activate the complement sequence. By generating appropriate signals into this complement sequence, the immune complexes engender their own uptake by phagocytic leukocytes from the circulation (attracted both by the generation of chemotactic factors and split products of the complement sequence). Once white cells take up the immune complexes they extrude their lysosomal enzymes: lytic ferments which break down connective tissue substrates. However, the lysosomal enzymes can also generate further chemotactic factors from the complement sequence. They themselves can generate the inflammatory kinins and they

can release further mediators of inflammation known as "cationic permeability proteins." Finally, it is during the uptake by phagocytes of immune complexes that prostaglandins and products of the lipoxygenase pathway are liberated (see below). Once lysosomal enzymes have gained access to the joint cavity from which they have been previously protected by virtue of their intracellular residence, the continued corrosion of joint spaces by lytic ferments leads to synovial lining cell multiplication and growth. The resulting response of the joint to these corrosive enzymes is the formation of pannus, which is nothing but a sort of granulation, or scar, tissue seen in long-term inflammation. This almost malignant transformation of the joint into an organ capable of producing autoaggressive pannus (filled with lymphocytes, plasma cells, macrophages, etc.) leads to the erosion of cartilage. Pannus tissue also produces enzymes (not necessarily lysosomal) such as those capable of cleaving collagen and, finally, synthesizes yet more prostaglandins. Some of these have been shown capable of causing dissolution of bone, as in the rheumatoid joint. It has also been shown that lysosomal enzymes released from the white cells can themselves alter more antibody molecules to produce more altered IgG. Altered IgG, in turn, acts as a positive feed-back enhancement of the inflammatory process.

This analysis of the most well-understood form of arthritis, rheumatoid arthritis, strongly suggests that inflammatory cells (polymorphonuclear leukocytes, joint cells themselves and invading macrophages) contribute most of the kind of inflammation encountered in human disease. Nonsteroidal anti-inflammatory agents do not block any critical event in the sequence, although they block prostaglandins which *amplify* this inexorable process. Thus it is clear that nonsteroidal anti-inflammatory agents are by no means capable of completely abrogating inflammation in rheumatoid arthritis. They can, however, by preventing the biosynthesis of prostaglandins, interfere with some of the positive feedback loops of inflammation. These will be discussed in terms of their effect upon prostaglandin synthesis, and contrasted with the mode of action of corticosteroids.

Steroid Hormones

The ability of adrenal corticosteroids to both suppress inflammation and compromise host defenses has been well documented. Recently, a series of *in vitro* and *in vivo* experiments, based upon our new knowledge of the cell biology of inflammation and

the biochemistry of the phagocytic cell itself, has suggested new insights into the mechanism not only of how steroids act, but have related their mode of action to the mode of action of nonsteroidal anti-inflammatory agents.

One current hypothesis as to the *physiologic* mode of action of steroid hormones describes diffusion of hormone across the plasma membrane where it is reversibly bound by a specific cytoplasmic glucocorticoid-binding protein, acting as a cytosol receptor.¹ After a conformational change of the receptor, the complex becomes capable of migrating into the nucleus of the cell, where it is bound to chromatin. This binding regulates the transcription of mRNA, and subsequent protein synthesis.² *In vitro* experiments utilizing hepatoma tissue culture cells have estimated that each cell contains about 150,000 receptor molecules.³ Work by Lippman and Thompson⁴ suggests that each tissue (eg, hepatoma cell or fibroblast) contains a specific cytoplasmic steroid receptor characteristic of that tissue, and that there is a distinct nuclear binding site for each type of receptor complex. This provides a theoretical explanation for the different effects of steroids, depending on the target tissue involved as steroid-receptor complexes bind to different areas of chromatin subsequently to set the machinery for selective protein synthesis. In the liver, for instance, induction of specific enzymes involved in gluconeogenesis has been clearly demonstrated after corticosteroid administration.⁵ In addition, there is evidence that steroids also act to regulate the translation process by which information contained in transcribed mRNA sequences is used to direct the assembly of proteins.⁶ The resulting influence of the above may be either anabolic, antianabolic, or catabolic in regard to the synthesis of proteins depending upon which cells and mRNA are involved. As an example, in the liver, glucocorticoid action results in the maintenance of adequate production and storage of glucose, whereas in peripheral tissues such as muscle, bone, and skin, glucocorticoids provoke pronounced antianabolic effects due to inhibition of amino acid incorporation into protein and DNA synthesis. After administration of glucocorticoid, plasma alanine concentration increases. This not only provides a marked increase in substrate for gluconeogenesis, but is also implicated in the increased secretion of glycogen by pancreatic alpha cells,⁷ which may account, in part, for the marked increment in hepatic glucose output after the administration of corticosteroid.

Steroids and Inflammation

However, the prompt response of acute in-

flammation in clinical states such as asthma, conjunctivitis, arthritis, or dermatitis strongly suggests that the effects of steroids on the slow processes of transcription and translation are insufficient to account for the therapeutic efficacy of massive doses of glucocorticoids. Consequently, attention has been drawn to effects of glucocorticoids on other aspects of inflammation. In the discussion that follows, our present concepts of the *pharmacologic* mechanisms related to inflammation will be reviewed.

Acute inflammation is usually characterized by increased vascular permeability, the migration of leukocytes into the inflamed area, the release of mediators of inflammation from leukocytes, and the interaction of these mediators with circulating proteolytic cascades such as the kinin, complement and coagulation systems. While it has been known for some time that the administration of corticosteroids reduces vascular permeability and reduces the number of leukocytes at the site of inflammation, it has only been recently appreciated that glucocorticoids have direct effects upon the effector cells themselves: the phagocytes (polymorphonuclear leukocyte, monocytes and tissue macrophages). In addition, it has been adequately documented that patients treated with high doses of steroids for long periods of time suffer from an increased incidence of infection.^{8, 9} Why is it that glucocorticoids (which significantly suppress inflammatory manifestations of rheumatic diseases) almost uniformly produce an enhanced susceptibility to infection? It is our understanding of the physiology of the phagocyte, and its response to inflammatory mediators, that has now allowed us to correlate both the anti-inflammatory effect of steroids and the effect of the agents on permitting bacteria to remain viable within the cells that are in fact designed for their elimination.

Over the past decade, studies in many laboratories have suggested and in some cases clearly established, that *pharmacologic* doses of steroids, both *in vitro* and *in vivo*, are capable of inhibiting each of the steps in the phagocytic-microorganism interaction. We will review this series of coordinated, but separable and discrete steps in the inflammatory process, and describe effects of steroids on each.

One of the earliest cellular events in inflammation is the chemotactically directed migration of phagocytes to the site of a foreign invader. Chemotactic factors may either be released from the microorganism itself, as demonstrated by Ward et al,¹⁰ or the microorganism can generate chemotactic factors (C3a, C5a, C567) after interaction with the complement sequence.¹¹ Several experimental systems have been utilized to study the effects of various

steroid compounds on phagocytic chemotaxis, frequently with conflicting results. The random motility of leukocytes in a capillary tube assay has been shown to be reduced in the presence of hydrocortisone.¹² Using rabbit PMN's in a Boyden chamber, Ward¹³ was able to demonstrate significant inhibition of chemotaxis in the presence of hydrocortisone and methylprednisolone in a concentration of 10^{-4} molar, Borel,¹⁴ on the other hand, was unable to produce inhibition of rabbit neutrophil chemotaxis *in vitro* with hydrocortisone, but when hydrocortisone-treated rats were used as a source for PMN's, inhibition of the chemotactic response could be shown.¹⁵ Majeski et al¹⁶ using human PMN's from normal donors, were able to demonstrate inhibition with methylprednisolone but not hydrocortisone, and again only in high concentrations (mg/ml range), suggesting that hydrocortisone required metabolic processing *in vivo* to exhibit inhibitory activity. However, it hardly needs to be stressed that these inhibitory effects on chemotaxis require the presence of steroid concentrations far above those normally achieved clinically ($>10^{-6}$ molar). In normal human subjects given a single large dose of steroids, chemotaxis has been found to be normal.¹⁷ Published studies to date have not described the chemotactic response of patients who have been treated with prolonged, high-dose steroids. The exact site of steroid interference with neutrophil chemotaxis demonstrated in the above systems has not been detailed.

Once the phagocyte has arrived in the vicinity of the microorganism, it must recognize the invader. The cells are signalled to engulf foreign bodies by one of two immune signals. In the first instance, antibodies present in the circulation of the prepared host bind to the surface of the microorganisms via the Fab portion of the Ig molecule. The Fc portions of Ig are subsequently exposed for recognition by surface receptors of granulocytes, platelets, and mononuclear cells. The second signal, recently shown by Ray and Wuepper¹⁸ to be important in infections caused by *Candida*, is generated when the cell wall of the microorganism activates the alternative pathway of complement activation resulting in the surface coating of the cell wall by the complement component C3b (or a closely related product). This C3 split product possesses opsonic activity and promotes immune adherence.

Schreiber et al,¹⁹ employing human red blood cells coated with either IgG or C3, have demonstrated the ability of hydrocortisone, at concentrations up to 10^{-4} molar, to inhibit both mononuclear phagocytic cell receptor activity for IgG and C3b in a

When the Fc or C3b receptors on the phagocyte recognize their respective signals, the cell rapidly responds with a series of profound metabolic changes associated with engulfment of the opsonized particles, such as bacteria, inside a phagocytic vacuole.

Chretien and Garagusi²⁶ and Mandel et al.,²⁷ have demonstrated that glucocorticoids affect *normal* granulocytes so that these now resemble the cells of patients with CGD. Steroids depress the oxidative metabolism of granulocytes *in vivo* as measured by the ability of the cells to reduce nitro-blue tetrazolium dye, a consequence of the formation of oxygen-derived free radicals (O_2^\cdot , OH^\cdot). Cooper²⁴ has shown inhibition of the HMS by several steroids *in vitro* with a concentration of 10^{-4} molar. Goldstein et al.,²⁸ in an *in vitro* system using human PMN's stimulated at their cell surfaces with aggregated IgG and C5a, have demonstrated the inhibition of super-

Generation of Thromboxanes, Prostaglandins and Derivatives of Arachidonic Acid

When a phagocytic cell encounters a particle, a phospholipase is activated which liberates fatty acids such as arachidonic acid from the cell membrane. One reaction of arachidonic acid is with oxygen catalyzed by the enzyme cyclooxygenase, which gives rise to the endoperoxides PGG_2 and PGH_2 (see review in ref. 29).

$$\begin{array}{c} \text{CH}_3 (\text{CH} = \text{CH})_n \text{CH} (\text{CH}_2)_n \text{COOH} \xrightarrow{\text{peroxidase}} \\ \quad \quad \quad \text{OOH} \\ \text{CH}_3 (\text{CH} = \text{CH})_n \text{CH} (\text{CH}_2)_n \text{COOH} + [\text{Ox}] \\ \quad \quad \quad \text{OH} \end{array}$$

Through isomerase reactions, the endoperoxides are transformed to several products including the stable PGE prostaglandins (PGE₂, PGF_{2α}), the thromboxanes and the newly recognized prostacyclin (PGI₂).

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platelets, granulocytes (and in soybeans!) there exist lipoxygenases which transform arachidonate, first to hydroperoxy acids (such as HPTE) and subsequently by the reaction described above, to hydroxy acids such as HETE. There is evidence that a slow-reactive substance (SRS) similar to that formed during anaphylaxis (SRS-A) is also generated by this pathway.³¹ Moreover, simple photooxidation by means of ultraviolet radiation, of arachidonate, yields HETE.

The role of superoxide anion (and the products of its reaction with H_2O_2 (OH^\cdot , $^1\text{O}_2^*$) in the generation of biologically active products from arachidonate has been recently explored by Perez and Goldstein.³² Exposure of arachidonate to a superoxide-generating system (xanthine oxidase and acetaldehyde) yielded a polar lipid product (*not* HETE) which proved to be one of the most potent chemotactic stimuli yet described to granulocytes. Rabbit peritoneal granulocytes, treated with indomethacin and stimulated by a calcium ionophore (A23187) release prodigious amounts of various positional isomers of HPTE and HETE.³³ It will be of interest to determine whether one or another of these is identical to the chemotactic lipid described by Perez and Goldstein.

Pro- and Anti-Inflammatory Effects of Prostaglandins

In several systems, endoperoxides, prostaglandins, and thromboxanes have been shown to be pro-inflammatory (review in ref. 34). PGE_1 is a known vasodilator, and when injected into normal human skin, produces erythema and the wheal and flare reaction. It has been shown to act synergistically with bradykinin and histamine to potentiate edema and can sensitize an individual to bradykinin-induced pain. In addition, Higgs and coworkers have shown that stimulated PMN release prostaglandin E_2 -like material that is chemotactic for PMN's. Also, bradykinin infusions in animal tissues have been shown to stimulate release of PGE_2 and $\text{PGF}_{2\alpha}$. It has been suggested that bradykinin may stimulate phospholipase activity to cleave arachidonic acid from phospholipid membranes, thus providing more substrate for PG synthesis.

Of the products described above, several are potent chemotactic agents: most notably HETE, HHT, and the various products derived via the enzymatic (lipogenase) or nonenzymatic oxidation of arachidonate.^{30, 31, 32, 33, 34}

However, other studies have shown that stable prostaglandins may be *anti-inflammatory*, by virtue of their ability to increase cyclic AMP and subse-

quent reduction in the extrusion of lysosomal enzymes from PMN's.³⁴

In various models of acute and chronic inflammation (adjuvant arthritis, carrageenin blebs), the repeated administration of PGE_1 had an anti-inflammatory effect. Moreover, most of the stable prostaglandins serve to inhibit mediator release from platelets, polymorphonuclear cells, eosinophiles and lymphocytes and their rank order in this capacity is directly related to their rank order in raising cAMP levels in the inflammatory cells.³⁴ Thromboxane A_2 has been shown to produce vasoconstriction³⁵ and platelet aggregation, while prostacyclin (PGI_2) has been shown to inhibit platelet aggregation and to cause vasodilation. Vane and coworkers,³⁶ who discovered prostacyclin, have postulated that the latter two compounds act respectively to promote and control the extent of thrombus formation.

It may be important to note that PGI_2 also raises cAMP in target tissue³⁰ and, in our hands, is even more potent than PGE_1 or PGE_2 with respect to its capacity to inhibit release of lysosomal hydrolases from human granulocytes.³⁷ In fact, all the evidence points to the conclusion that PGI_2 is simply another PGE_1 -type of compound. Like PGE_1 , it potentiates edema, vasodilation, the response to bradykinin³⁰ but, with respect to the release of mediators of inflammation it can be considered anti-inflammatory. Finally, PGI_2 is far more abundant in normal and inflamed tissues than is PGE_1 .

Steroids, Nonsteroidal, Anti-Inflammatory Agents and Prostaglandins

It is now generally appreciated that aspirin and indomethacin inhibit the transformation of arachidonic acid — via appropriate intermediates — to stable prostaglandins (PGE_2 , $\text{PGF}_{2\alpha}$), prostacyclin and the thromboxanes by inhibiting cyclooxygenase.³⁸ Other nonsteroid anti-inflammatory substances such as phenylbutazone, naproxen, and mefenamic acid also inhibit prostaglandin biosynthesis by this means. By contrast, steroidal anti-inflammatory drugs do not inhibit the activity of the "prostaglandin synthetase" system in microsomal fractions. In a series of experiments utilizing inflamed rat synovium, Floman et al³⁹ were able to demonstrate marked suppression of prostaglandin release by incubation with corticosterone, dexamethasone or prednisone. Noninflammatory steroids such as aldosterone and progesterone had no effect. In addition, the suppressive action of cortisone on PGE release could be reversed by the addition of arachidonic acid. By contrast, the inhibitory

action of indomethacin was not affected by provision of exogenous substrate. Chang and coworkers⁴⁰ have recently demonstrated the inhibition by glucocorticoids of prostaglandin release from adipose tissue in an *in vitro* system, while Heraczynska et al.,⁴¹ in an *in vivo* system utilizing whole limb perfusion, have shown suppression of the release of PG-like substances by hydrocortisone. Gryglewski⁴² has summarized various experimental systems in which glucocorticoids inhibit release of prostaglandins and thromboxanes. These now include:

1. The isolated, perfused guinea pig lung challenged by antigen or a releasing factor (RCS-RF).
2. Blood vessels which release prostacyclin after prolonged vasoconstriction induced by noradrenalin.
3. The perfused cat spleen similarly stimulated with noradrenalin.
4. Incubated slices of mesentery from ovalbumin-sensitized guinea pigs exposed to antigen.
5. Inflamed ocular tissues which release prostaglandins.
6. Dogs or cats suffering from shock sufficient to raise myocardial prostaglandin levels.
7. Human psoriatic skin which contains excessive amounts of HETE. Moreover, Flower and coworkers^{43, 44} have shown that stimulated lung tissue failed to release free arachidonate from membrane phospholipids in the presence of glucocorticoids under circumstances in which both the cyclooxygenase and the lipoxygenase pathways were blocked by an appropriate inhibitor (TYA). They were not able to show that steroids interfered with phospholipase activity in cell-free tissue homogenates. Finally, Goldstein and co-workers⁴⁵ have shown inhibition of thromboxane generation by phagocytosing human leukocytes, after preincubation of cells with hydrocortisone. Each of these findings strongly suggests that stabilization of the plasma membranes by cortisol has made arachidonic acid (the substrate) less accessible to phospholipases, presumably by packing phospholipid bilayers.

The Human Granulocyte: Drug Effects

Consequent to the metabolic changes and release of thromboxane and prostaglandins from phagocytes are cellular rearrangements which involve degranulation of lysosomes into the phagocytic vacuole which contains the invading microorganism. Degranulation appears to be associated with the assembly of intracytoplasmic microtubules, changes in the levels of cyclic nucleotides (cAMP, cGMP) and the activation of contractile, intracellular proteins re-

lated to actin, myosin and accessory proteins.⁴⁶ During the degranulation process, a variety of antibacterial substances are released into the phagocytic vacuole. Many of these substances exist preformed within the lysosome. On the other hand, hydrogen peroxide is newly formed inside the phagocytic vacuole and, as discussed above, is utilized as one mechanism whereby the host cell kills the invading organism.

Studies from many laboratories, especially our own, have indicated that steroids interfere with a wide variety of membrane functions, including those of the plasma membrane of the white cell, the plasma membrane of the erythrocyte, and the membrane of lysosomes.⁴⁷ Indeed, corticosteroids influence the permeability and stability of artificial lipid structures: liposomes. Studies employing liposomes have clearly shown inhibition of membrane fusion in the presence of as little as 1 molar percent cortisol within the lipid bilayer.⁴⁸ Perhaps even more important with respect to inflammation is the observation that treatment of cells with corticosteroids prevents release of lysosomal hydrolases into surrounding fluids after phagocytosis.²⁸ This may be directly related to reduced rates of fusion of lysosomes with the plasma membrane or to modulation of receptor-ligand interactions at the cell surface. The ability of steroids to inhibit this fusion may reflect their ability to enter into, and influence the deformity of, lipid bilayers. That hydrocortisone, so inserted, can prevent membrane perturbation by immune reactants has recently been measured as the diminished perturbation (determined by electron spin resonance spectroscopy) produced in artificial lipid membranes (liposomes) by aggregated IgG.⁴⁹

Summary

The general membrane effects of corticosteroids may indeed explain the capacity of these agents both to inhibit inflammation and to prevent the appropriate digestion of offending microorganisms. In contrast, nonsteroidal anti-inflammatory agents seem to have rather limited effect on phagocytic cells. The different properties of steroidal and nonsteroidal anti-inflammatory agents can, perhaps, be understood with reference to the following:

The anti-inflammatory effect of such agents as aspirin and indomethacin can be explained almost entirely by virtue of their ability to inhibit cyclooxygenase, thus preventing the transformation of arachidonic acid to both endoperoxides and thromboxanes. These inflammatory substances, which mediate mainly vascular reactivity and platelet aggregation, do not seem to be involved in bacterial

killing *per se*. Thus, cells treated with nonsteroidal anti-inflammatory agents should release fewer phlogistic substances than control cells, but still be able to participate in the fusion of lysosomes to the plasma membrane and to undergo the oxidative burst of respiration: they should be able to release antibacterial substances into phagocytic vacuoles. In fact, cells from patients treated with these agents should be able to kill normally. Indeed, this has been found to be the case: the only function of white cells affected by nonsteroidal anti-inflammatory agents appears to be their capacity simply to adhere to surfaces.⁵⁰

As described above, recent experiments show that cortisol inhibits the formation of prostaglandins and thromboxanes in phagocytosing cells, an end result which resembles that produced by treatment of patients or cells with aspirin. However, there is a significant difference. If one adds exogenous arachidonic acid to aspirin-treated cells or to cells from aspirin-treated patients, one cannot reverse the block of prostaglandin or thromboxane synthesis. This is because aspirin inhibits the cyclooxygenase enzymes required to transform arachidonate. In contrast, the addition of exogenous arachidonate overcomes cortisone-induced inhibition of prostaglandin and thromboxane formation, indicating a site of action proximal to the release of arachidonic acid. Moreover, steroid-treated cells cannot generate chemotactic products such as HETE formed via the lipogenase pathway or by non-enzymatic means (photooxidation or O_2^- generation). Since cortisone reduces the mobility of artificial and plasma membranes and fusion of lysosomes with the phagocytic vacuole derived therefrom, one would expect many plasma membrane-associated functions to be inhibited.

We are therefore in a position to explain why patients treated with nonsteroidal anti-inflammatory agents can effectively combat infections. The cells can recognize the invader, they can respond to it metabolically, they can degranulate their lysosomal contents and they are able to generate those oxygen-derived free radicals hydrogen peroxide, which are involved in the ultimate killing of such microorganisms of *Staphylococcus* and *Candida*. In contrast, corticosteroids have more profound effects. By inhibiting the production of superoxide anion and subsequent hydrogen peroxide production in the phagocytic vacuole, they will interfere with the killing of precisely those microorganisms (eg, *Pseudomonas*, *Staphylococci*, *Candida*) which require the halide-linked peroxidase system to eradicate the infection. Moreover, because release of lysosomal

hydrolases is diminished, antibacterial and inflammatory substances contained within these granules will be denied access to the phagocytic vacuole or the cell exterior. The cortisol-induced inhibition of endoperoxide, thromboxane and prostaglandin generation may well explain those anti-inflammatory actions that cortisone shares with aspirin.

Thus, it is clear that if only modest anti-inflammatory regimens are required, it is preferable, with respect to host defenses, to employ nonsteroidal anti-inflammatory agents, which cannot impair host defenses. From the above scheme it will also be obvious that glucocorticoids are both much more effective anti-inflammatory agents while at the same time more dangerous with respect to disarming the host cell before its encounter with microorganisms. This new understanding of the pharmacologic mode of action of cortisol on phagocytic cells explains, we believe, how glucocorticoids at the same time alleviate inflammation, while permitting multiplication of the offending microorganism within the phagocyte designed for its destruction. ★★★

550 First Avenue (10016)

References

1. Hackney, J. F. and Pratt, W. B.: Characterization and partial purification of the specific glucocorticoid-binding component from mouse fibroblasts. *Biochemistry* 10:3002, 1971.
2. Comstock, J. P., Rosenfield, G. C., O'Malley, B. M. et al.: Estrogen-induced changes in translation, and specific messenger RNA levels during oviduct differentiation. *Proc. Natl. Acad. Sci.* 69:2377, 1972.
3. Baxter, J. D. and Tomkins, G. M.: Specific cytoplasmic glucocorticoid hormone receptors in hepatoma tissue culture cells. *Proc. Natl. Acad. Sci.* 68:932, 1971.
4. Lippman, M. E. and Thompson, E. B.: Differences between cytoplasmic glucocorticoid-binding proteins shown by heterogeneity of nuclear receptor sites. *Nature* 246:352, 1973.
5. Julian, J. A. and Chytil, F.: A two-step mechanism for the regulation of tryptophan pyrrolase. *Biochem. Biophys. Res. Commun.* 34:734, 1969.
6. Tomkins, G. M., Gelehrter, T. D., Granner, D. et al: Control of specific gene expression in higher organisms. *Science* 166:1474, 1969.
7. Marco, J., Calle, C., Roman, D., Diaz, F., Villancueva, M. and Valverde, I.: Hyperglucagonism induced by glucocorticoid treatment in man. *N. Engl. J. Med.* 288:128, 1973.
8. Staples, P. J., Gerding, D. N., Decker, J. L. et al: Incidence of infection in systemic lupus erythematosus. *Arthritis and Rheum.* 17:1, 1974.
9. Burry, H. C.: Bacteriuria in rheumatoid arthritis. *Ann. Rheum. Dis.* 32:208, 1973.
10. Ward, P. A., Lepow, I. H. and Newman, L. J.: Bacterial factors chemotactic for polymorphonuclear leukocytes. *Am. J. Path.* 52:725, 1968.

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- **only a 60% cure rate with penicillin V-K**



As seen on admission



After one week of penicillin V-K therapy



Two weeks after initiation of TEGOPEN therapy

Treatment failure was judged to have occurred when lesions increased in size and/or number during the initial week of treatment with penicillin V-K. No treatment failures occurred with Tegopen.

*Data on file, Bristol Laboratories.

Brief Summary of Prescribing Information

TEGOPEN®
(cloxacillin sodium)
Capsules and Oral Solution

For complete information, consult Official Package Circular.

(12) 9/11/75

INDICATIONS:

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

RESULTS OF ORAL THERAPY revealed a high percentage of treatment failures with penicillin V potassium, but *no* failures with Tegopen.

		Given Tegopen® (cloxacillin sodium)	Given penicillin V-K
<i>Staphylococcus aureus</i>	(78 patients)	39	39
Returned to clinic at one week		29†	38†
Treatment failure at one week		0	18 (47.4%)
<i>Staphylococcus aureus</i> and <i>Streptococcus pyogenes</i>	(9 patients)	4	5
Returned to clinic at one week		4	5
Treatment failure at one week		0	2 (40%)
No initial bacterial growth	(14 patients)	9	5
All 14 healed, regardless of which antibiotic was administered.			
Beta-hemolytic <i>Streptococcus</i>	(1 patient)	0	1
TOTALS:	102 patients	52 patients	50 patients

†Eleven patients did not return for their one-week checkup. These were all called by telephone, and their families reported

the lesions had healed. One patient was dropped from the study, early, because of adverse reaction to medication.

**STUDY:
DESCRIPTION/PROTOCOL**

- 102 nonselected subjects, with initial bacteriology as follows: 77% *Staphylococcus aureus*, 9% mixed *Staphylococcus aureus* and *Streptococcus pyogenes*, and 1% beta-hemolytic *Streptococcus*.†
- All patients were given randomized therapy—Tegopen capsules or oral solution, or penicillin V-K tablets or oral solution, in recommended dosages according to body weight.

- All patients were evaluated after one week's therapy. If there was no improvement, therapy was switched to the other antibiotic. The "other antibiotic" proved to be Tegopen 100% of the time because no treatment failures had occurred with Tegopen.
- A final assessment of progress was made two weeks after initiation of Tegopen therapy.

†The remainder, to equal 100%, consisted of 14 patients (13%) who exhibited no initial bacterial growth. These 14 were all healed, whether given Tegopen or penicillin V-K.

TEGOPEN®

(cloxacillin sodium)

**—effective therapy for staph infections
of the skin and skin structures**

WARNING:

Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

PRECAUTIONS:

The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:

Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose

stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:

Adults: 250 mg. q 6h.

Children: 50 mg./Kg./day in equally divided doses q 6h. Children weighing more than 20 Kg should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

SUPPLIED:

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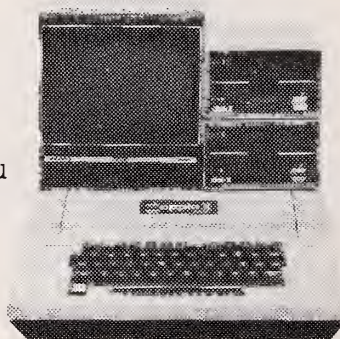
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†Due to susceptible organisms.

1. Ginsburg CM, McCracken GH Jr, Zweighaft TC, Clahsen JC: Comparative pharmacokinetics of cyclacillin and amoxicillin in infants and children. *Antimicrob Ag Chemother*

19:1086-1088 (June) 1981.

2. Multicenter trials. Data to be published.

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†Due to susceptible organisms.

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Cyclapen®-W (cyclacillin)

Indications

Cyclacillin has less *in vitro* activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci

Branchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)

Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*

Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS. It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Branchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.

†depending on severity

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The President Speaking

Our 114th Annual Session Needs You

R. FASER TRIPLETT
Jackson, Mississippi

In just a few short weeks our association will conduct its 114th Annual Session, and stories in the February and March issues of JOURNAL MSMA highlight some of the many business, scientific and social events of that occasion. I hope you are planning to attend.

Although this is the 114th annual meeting of the association, it will mark our 125th anniversary year. The association was founded on December 15, 1856 at a meeting in Jackson and did not meet again until 1869. The tradition of an annual membership meeting featuring business, scientific and social events has continued since that time.

The importance of voluntary associations, such as our county, state and American Medical Association, in our country's history was identified by the noted French writer, Alexis de Tocqueville. Traveling in America in 1830, Tocqueville observed, "Americans of all ages, all stations of life, and all type of dispositions are forever forming associations . . ." and he further noted that America drew its strength from such associations. A conclusion he drew from this observation was that ". . . in countries where such associations do not exist if private people do not artificially and temporarily create something like them, I see no other dyke to hold back tyranny of whatever sort, and a great nation might with impunity be oppressed by some tiny faction or by a single man."

Our association is only as strong and viable as the participation of its members. I know of no other place where all the physicians of this state can gather to promote the art and science of medicine. I know of no other place where you as a member of a learned profession can make your views known and through a democratic process forge those views into a national agenda for action.

Mark your calendar now to attend our 114th Annual Session May 2-6 in Biloxi. We need you and you need your association.

★★★

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXIII, Number 3

MARCH 1982

Meniere's Disease, An Overworked Diagnosis

One hundred and twenty-one years ago Prosper Meniere described a syndrome that today still bears his name. The classic triad of symptoms consists of vertigo, hearing loss, and tinnitus. As a clinical entity, Meniere's syndrome is relatively uncommon and is severely over-diagnosed.

The pathophysiology of this syndrome is specific and has not been found related to allergy, vascular insufficiency, drugs, endocrine changes, infectious disorders or metabolic problems, even though all of these may in their own right cause dizziness. Meniere's syndrome is caused by an increase of fluid pressure in the endolymphatic system suspended in the perilymph of the inner ear. The cause of the imbalance between secretion and resorption of endolymphatic fluid producing the pressure change has not been defined, but many clinicians feel that it is caused by blockage of the excretory duct, the endolymphatic duct. With increasing pressure, the endolymphatic sac ruptures and there is an acute mixing of the endolymph and perilymph fluids which are of different chemical makeup. This acute rupture and mixing of the fluids causes the severe, acute vertiginous attack. With healing of the perforation, vertigo clears but tinnitus and hearing loss may remain.

Clinically, Meniere's syndrome is characterized by repeated attacks of severe, debilitating vertigo with associated nausea and vomiting. These last from several minutes to 24 hours. The interval between episodes varies from several days to a year. All three components of Meniere's syndrome are not usually seen with the first attack, but invariably are present by the end of one year. Vertigo is the most common and severe first symptom. In 95 percent of cases, only one ear is involved.

Diagnosis is established by the history of recurring attacks of vertigo, nystagmus toward the involved ear during the acute vertiginous attack, documentation of a hearing loss with associated recruitment, and the subjective complaint of tinnitus.

Medical therapy aimed at reducing endolymphatic pressure includes diuretics and low salt diet. Anti-vertiginous drugs may be helpful in suppressing vestibular output with relief of symptoms. Patients with the more severe form of Meniere's disease with frequent vertiginous attacks and complete loss of hearing can be helped by a surgical labyrinthectomy with destruction of the involved inner ear. Patients with serviceable hearing and intractable vertigo are treated by selective resection of the vestibular nerves in the depths of the internal auditory canal by a transtemporal craniotomy approach.

While there are many causes of dizziness and many dizzy patients are encountered in most medical practices, only approximately one percent of the patients presenting with dizziness will have true Meniere's disease. The triad of symptoms, and particularly the intermittent vertigo, distinguishes this syndrome from many of the other causes.

MYRON W. LOCKEY, M.D.
Associate Editor

LETTERS

SIRS: I was pleased to see your article on cost containment in the recent MSMA JOURNAL. The cost of health care has reached alarming heights, forcing many Mississippians to cancel their coverage or change to a lower quality coverage. We only need to look at our own Medicaid Program to see that responsible financial planning is full of problems.

Some experts in health care suggest that physicians change their practice patterns. Others suggest reduction in hospital services and supplies. I do not

LETTERS / Continued

feel this approach is acceptable for Mississippi physicians or hospitals. The new technologies of the present and those just over the horizon must be furnished by hospitals for physicians' use in their practice. If our health providers do not furnish this technology, then both hospital and physician will face increasing numbers of malpractice suits.

Cost containment is viable, but to attain creditable savings, we must have the cooperation of physicians, hospitals, third party payors, employers, and the employees. Each must be educated on the cost of health care. Each must do all within his/her grasp to see that health insurance is available, needed hospital services are within our state, adequate physicians' services (both rural and urban), and all of us must encourage life styles to enrich individual health.

Blue Cross and Blue Shield of Mississippi is working closely with the hospital and physician community to encourage physical fitness and better life styles, introducing new contracts using co-payments and caps on payments, contracts with incentives for outpatient and office care, and finally, education of groups and non-groups about proper use of health facilities within our state.

Now is the time for all of us to work together to see that the people of our state receive health care that is proper and affordable.

W. E. CALDWELL, M.D., Medical Director
Blue Cross-Blue Shield of Mississippi
P.O. Box 1043
Jackson, MS 39205

Medico-Legal Brief

Malpractice Suits Establish New Records

Recent malpractice suits in Alabama and California have established new records in an area of law where the incredible becomes even more incredible.

In Alabama, a new record was established when a Mobile County Circuit Court recently awarded \$2.5 million in punitive damages to the father of a four-year old who died on the operating table during heart surgery. According to the plaintiff, the child died of massive blood clots caused by the negligent failure of a nurse-anesthetist employee of an anesthesiology group to administer an injection of heparin. The defense claimed the drug was administered, but the plaintiff brought in a handwriting expert who testified that records had been altered to make it appear heparin had been given.

In California, a court-imposed medical standard was established when the State Supreme Court recently found an established medical standard of care to be inadequate, and replaced it with its own standard. The case involved a female patient whose physician advised her on numerous occasions over several years to undergo a Pap smear in conformance with the community's standard of practice. It was later discovered that the woman's cervix had been largely replaced by a cancerous tumor too far advanced to be successfully treated and she died.

The California Supreme Court found that in spite of the physician's following the community's standard of care and recommending a Pap smear, he had an additional (court-imposed) duty to advise the patient of all material risks involved in the patient's refusal to undergo a recommended diagnostic test.



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MSMA's 114th Annual Session, May 2-6 Offers Varied Scientific Program

A widely varied scientific program will combine with a heavy agenda of business meetings and a full calendar of special activities to make the 114th Annual Session of the Mississippi State Medical Association bigger than ever. The five-day session is scheduled for May 2-6, 1982, at the Biloxi Hilton. In announcing preliminary plans, Dr. J. Elmer Nix of Jackson, chairman of the Council on Scientific Assembly, noted that in addition to regularly scheduled activities, this year's meeting also features special events to commemorate the association's 125th Anniversary Year.

Outstanding speakers have been scheduled for the scientific meetings, which begin Sunday, May 2 and continue through Wednesday, May 5.



Dr. Robert Bucklin, deputy medical examiner of Los Angeles and member of the Shroud of Turin Research Project, will be guest speaker at the meeting of the Section on Pathology, Sunday, May 2, during MSMA's 114th Annual Session. Dr. Bucklin will make a second presentation later in the day at a special public session.

One speaker, Dr. Robert Bucklin of Los Angeles, will make a double presentation on the opening day of the scientific session. He will address the Section on Pathology that morning and will make a second presentation that afternoon at a special session open to the public.

Dr. Bucklin, a forensic pathologist, is a member of the team of investigators which in 1978 began scientific testing of the Shroud of Turin. For six centuries the shroud has been regarded by many as the burial garment of Jesus Christ, and its authenticity has been widely debated. The cloth attracted the attention of scientists in 1898 when an Italian photographer made a remarkable discovery. In taking pictures of the shroud, he discovered that the image of a man which appears on the cloth was actually a negative. Not only were all details reversed on the photographs, there were also much more vivid and lifelike than those seen on the original.

Studies in the early 1900s produced a physical description of the man whose image appears on the cloth and a description of his wounds. Later studies determined that the cloth was certainly ancient — and quite possibly 2,000 years old.

Prior to 1978, when the Shroud of Turin Research Project began its investigation, studies of the relic were limited primarily to examination of photographs, the best of which had been prepared in 1931. The current researchers subjected the cloth to a full range of tests possible through modern science, and it is those tests which Dr. Bucklin will describe in his presentation. Although all of the scientists in the project did not reach the same conclusion, many of them, including Dr. Bucklin, have stated that there is support in the data for the literal, physical resurrection of Jesus.

In addition to the section on pathology, six other scientific sections will meet on the opening day, including anesthesiology, psychiatry, orthopedic surgery, EENT, radiology, and dermatology. Tuesday's schedule includes meetings of the sections on

ANNUAL SESSION/Continued

medicine, preventive medicine and surgery; and the schedule for Wednesday includes the sections on family practice, ob-gyn, pediatrics and urology.

At press time, scheduled out-of-state speakers and their topics include: Dr. Mitchell Sams of Birmingham — *Dermatological Diseases Produced by Drugs*; Dr. John M. Hodges of Memphis — *External Rhinoplasty and Local Anesthesia of the Head and Neck*; Dr. Thomas Sisk of Memphis — *The Shoulder and The Knee*; Dr. D. J. Aronberg of St. Louis — *What CT Can Tell About the Mediastinum and Guided Needle Biopsy of Chest and Abdomen Lesions*; Dr. William Logan Webb of Memphis — *Psychosomatic Aspects of Chronic Pain*; Dr. Paul J. Wiesner of Atlanta — *Venereal Disease Update*; Dr. Ronald Okun of Los Angeles — *Hypertension Update*; and Dr. George Thomas Laven of Birmingham — *Pediatric Nutrition: Current Concepts*.

The April issue of JOURNAL MSMA will include full details about the 114th Annual Session, including the complete scientific program, information about meetings of House of Delegates and specialty societies, the special events calendar, and full program for the MSMA Auxiliary's 59th Annual Session.

MSMA President Elected Regent Of American College of Allergists

R. Faser Triplett, M.D., of Jackson, recently was elected a member of the Board of Regents of the American College of Allergists at the organization's 38th Annual Congress in Bal Harbour, Florida, Jan. 16-20.

Dr. Triplett will serve a three-year term on the governing body of the College, a national medical organization whose 2100 office-based members specialize in treating patients with allergic disease.

Dr. Triplett, currently president of the Mississippi State Medical Association, is clinical assistant professor of pediatrics at the University of Mississippi Medical Center. He is on the staffs of the University Hospital and Baptist Hospital, and has been in private practice in Jackson since 1966.

Dr. Triplett received his medical degree from Tulane University and interned at Southern Pacific Hospital, San Francisco. He was in residency at the University of Tennessee Hospital and at the University of Colorado Hospital.

Medical Assistants Will Meet in Jackson

The annual convention of the American Association of Medical Assistants, Mississippi Society, will be held in Jackson at the Ramada Inn Metrocenter, April 16-18, 1982.

The program for the opening day includes morning workshops on "Communications," chaired by James Hughes, M.D., chief of the Division of Orthopaedics, University Medical Center, and "What Makes You Act Like You Act," chaired by Mrs. Pat Maxey, state educator. Speaker for the afternoon session is Faye Spruill, M.D., medical examiner for Mississippi, who will discuss the duties of her office.

A tour and reception at the Governor's Mansion will begin at 2:30 p.m. on Friday, and a hospitality hour and banquet at the Ramada Inn will conclude the day.

Saturday's schedule includes a general business session and an awards luncheon, followed by a workshop conducted by a representative from the national office of the AAMA, and a tour of Highland Village. The installation banquet is scheduled for Saturday evening. Charles Mathews, MSMA executive secretary, will be master of ceremonies, and Sidney Graves, M.D., MSMA president-elect, will be guest speaker. A prayer breakfast on Sunday will close the convention.

For convention information, call Onie Johns, 956-0940 or 362-6323.

National Organizations Seek Health Cost Solutions

The American Medical Association has joined with five other national organizations in endorsing the concept of voluntary local coalitions to tackle the problems of health care costs, quality and access.

In addition to the AMA, organizations involved are the American Hospital Association, Blue Cross and Blue Shield Associations, Business Roundtable, Health Insurance Association of America, and American Federation of Labor and Congress of Industrial Organizations.

The new emphasis on private solutions and the withdrawal of federal funding in health were cited as major factors in the encouragement of local coalitions by the affiliates of the national organizations to put into effect common programs for utilization review and other activities to restrain health care cost increases.

Humana Announces New Health Plan in Jackson

Humana, Inc., a national hospital corporation and owner of Doctor's Hospital in Jackson, will establish what it calls a "Preferred Provider Plan" in Jackson for employees of interested companies. In the words of Humana the plan "... combines the best features of HMOs and standard (health insurance indemnity) plans."

Promoted as a health cost containment program, Humana claims that the program will provide a 5%-10% reduction in claims for the companies who participate.

The "Preferred Provider Plan" provides, among other things, for a closed panel of physician partici-

pants from among which employees would select a primary care physician. A medical director will approve all non-emergency hospital admissions. Physicians participating in the plan would agree to accept fees pegged at 20% below usual and customary fees in the community.

Answering the question why a hospital corporation would be interested in containing costs, Humana states, "We simply want to participate in the trend rather than be victimized by it. If Humana can provide employers with more cost effective health care delivery systems, we feel we can then attract the employers' business to Humana hospitals."

Humana's "Preferred Provider Plan" is expected to become operational in Jackson this spring.

Are the results of
\$100 million worth of
government-funded research
on hypertension
worth reading about?



Dole Foresees More Health Reductions

According to the chairman of the Senate Finance Committee, Senator Robert Dole (R.-Kan.), federal health programs "will continue to be a highly visible target for reductions this year."

Speaking to an annual meeting of the American Hospital Association in Washington recently, Senator Dole stated that he also didn't believe Congress or the Reagan Administration would stand by "... while (health) costs increase at nearly double the rate of inflation." Dole further stated "... to be perfectly frank, skepticism is in abundant supply on Capitol Hill as to whether or not the health care industry itself can really moderate its costs."

Among cuts the Administration is reportedly expected to recommend for Medicare and Medicaid are a flat two percent reduction in the Medicare reimbursement rate for hospitals; a limitation of five percent in the use for the physicians' fee screen under Medicare Part B; limitation of physician reimbursement for service in hospital outpatient departments; and indexing of the Medicare Part B physicians' services deductible to the Consumer Price Index.

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AMA Supports Private Practice Option

The American Medical Association has been awarded a \$300,000 physician placement contract to help the National Health Service Corps place Private Practice Option physicians in communities suited to them.

Corps scholarship physicians who select the option are released from their government service obligations if they establish a private practice in Health Manpower Shortage Areas.

The AMA will seek to place such physicians in communities where their practices will have a good chance of success. The AMA will identify and develop potential sites by matching a list of physician vacancies to a list of shortage areas and by working with local and state medical organizations. They will screen the list to insure that the communities are receptive to Corps placements.

Ophthalmologists Urge Repeal Of Cataract Legislation

The American Academy of Ophthalmology has called for repeal of legislation which provides Medicare reimbursement to optometrists for services provided to patients who have had cataracts removed.

The Academy cited an independent actuarial study by The Orkand Corporation indicating that the new benefit will cost Medicare \$36.5 million from 1982 through 1985, compared to the \$2 million annual cost estimated when the legislation was passed in 1980.

Of the \$36.5 million estimated payments to optometrists for the four-year period, \$18.1 million represents duplication of services already covered in the ophthalmologist's surgical fees, the Academy said.

Medicare beneficiaries and other health insurers will pay an additional \$15.6 million as a result of the legislation, according to the study, and Academy officials called that "a conservative estimate."

In a meeting with officials of the Department of Health and Human Services, Academy officials also cited concerns about risks to post-cataract surgery patients who are monitored by nonphysicians. The Academy stated these patients are subject to such complications as retinal detachment and glaucoma, which only physicians are trained to handle.

POSTGRADUATE CALENDAR

March 25-26, 1982

FOURTH ANNUAL NEUROLOGY SPRING SYMPOSIUM
Emphasis on Seizure and Sleep Disorders
Holiday Inn Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Neurology and Neurosurgery, the Veterans Administration Medical Center Neurology Service and the Medical Center Division of Continuing Health Professional Education.

Coordinator: Shri K. Mishra, M.D., associate professor of neurology, University of Mississippi School of Medicine, and chief of the neurology service, Veterans Administration Medical Center.

This symposium will provide an update on sei-

zures and sleep disorders for neurologists, neurosurgeons, internists, pediatricians, psychiatrists and family practitioners. Sessions include diagnosis and treatment of seizure disorders, classification of sleep disorders and sleep apnea. Fee: \$150. Credit: 11.25 contact hours (1.125 CEU), Category I of the AMA Physician's Recognition Award, AAFP.

April 3, 1982

THIRD ANNUAL SPRING SONIC SYMPOSIUM
University Medical Center, Jackson

Sponsored by the Mississippi Ultrasound Society and the University of Mississippi Medical Center Division of Continuing Health Professional Education.

Coordinator: Sandra A. Rhoden, M.D., president, Mississippi Ultrasound Society.

This course is designed to update the radiologist's and sonographer's knowledge of diagnostic ultrasound by covering the state of the art and current diagnostic procedures. Sessions include

In 1977, when
the Veterans Administration
compared Step-2
regimens in 450 mild
hypertensive patients,
which regimen was
proven most effective?



sonography of the placenta, ultrasonography of the jaundiced patient and noninvasive vascular studies emphasizing carotid ultrasound. Fee: \$125 for physicians and \$45 for sonographers. Credit: 6.5 contact hours (.65 CEU). Category I of the AMA Physician's Recognition Award.

April 24, 1982

UROLOGY VISITING PROFESSOR PROGRAM
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Surgery Division of Urology and the Medical Center Division of Continuing Health Professional Education.

Coordinator: W. Lamar Weems, professor of surgery (urology) and chief of the division of urology, University of Mississippi School of Medicine.

This seminar is designed to cover the latest developments in genitourinary trauma and bladder dysfunction. Guest speaker is Dr. Fletcher C. Derrick, clinical professor of urology at the Medical University of South Carolina. The program is made possible in part by the Urology Continuing Medical Education Fund of the Uni-

versity of Mississippi Alumni Association. There is no registration fee. Credit: 5 contact hours (.5 CEU) Category I of the AMA Physician's Recognition Award.

May 22-23, 1982

NUCLEAR MEDICINE UPDATE
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Radiology Division of Nuclear Medicine, the Medical Center Division of Continuing Health Professional Education and the Mississippi Society of Nuclear Medicine.

Coordinator: Jane Sanders, M.D., assistant professor of radiology, University of Mississippi School of Medicine.

This program will focus on developments in clinical nuclear medicine imaging. Major emphasis is on newer techniques as well as recent advances in established procedures. Fee: \$65 for Mississippi Society for Nuclear Medicine physician members; \$75 for nonmembers. Credit: 8 contact hours (.8) CEU, Category I of the AMA Physician's Recognition Award.

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Faculty Announced For Nuclear Medicare Update

Care of nuclear medicine equipment, interpretation of bone scans, gamma cameras, thallium imaging and liver scanning are among topics planned for a nuclear medicine update May 22-23 at the University of Mississippi Medical Center in Jackson.

The seminar, which will include the fifth annual meeting of the Mississippi Society of Nuclear Medicine, is sponsored by the UMC School of Medicine Department of Radiology Division of Nuclear Medicine, the Medical Center Division of Continuing Health Professional Education and the Mississippi Society of Nuclear Medicine. Partial support is from the Sloan Visiting Professor Fund in Radiology of the Medical Alumni Chapter of the University of Mississippi Alumni Association.

Guest lecturers include Dr. Lawrence Muroff, associate professor of radiology at the University of South Florida and director of nuclear medicine at the University of Alabama in Birmingham; and Dr. James D. Massie, assistant professor of radiology and nuclear medicine at the University of Tennessee Medical Center.

Dr. Jane Sanders, UMC assistant professor of radiology, is course coordinator. Dr. W. Mel Flow-

ers, UMC associate professor of radiology and director of nuclear medicine, will preside.

For information, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone: 987-4914.

UMC Will Host Sonic Symposium

Diagnostic ultrasound is the focus of the University of Mississippi Medical Center's third annual spring sonic symposium scheduled for April 3 at the Medical Center in Jackson.

The program, designed for radiologists and sonographers, is sponsored by the Mississippi Ultrasound Society and the Medical Center Division of Continuing Health Professional Education with support from the Robert D. Sloan Continuing Medical Education in Radiology Fund of the Medical Alumni Chapter of the University of Mississippi Alumni Association.

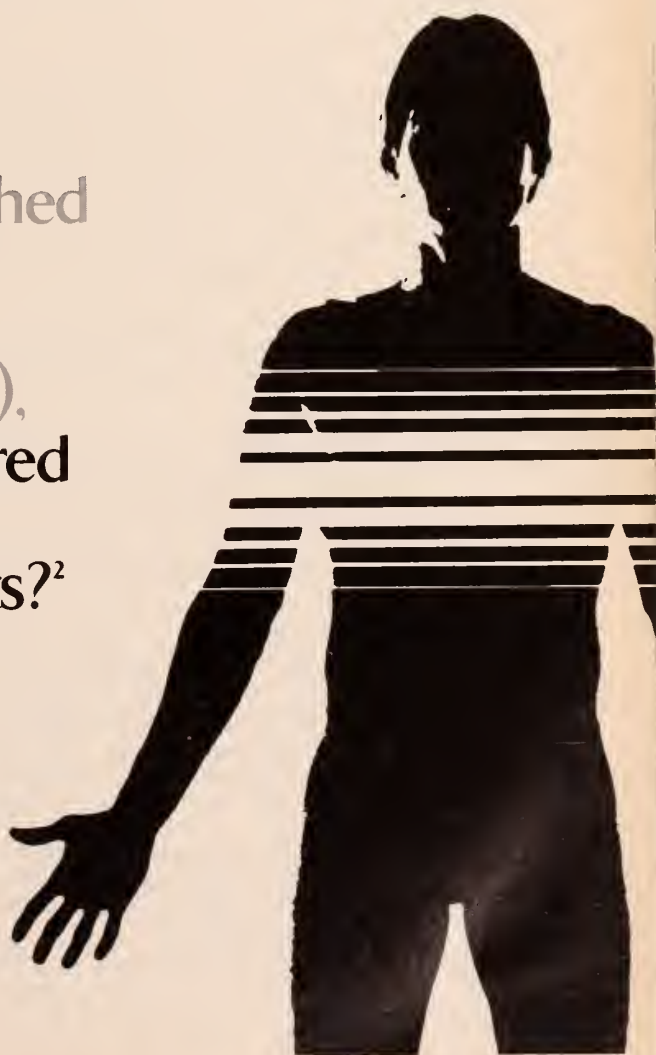
Speakers include Dr. Jay Crittenden, director of diagnostic ultrasound at West Florida Medical Center in Pensacola; Dr. Arthur Fleischer, assistant professor of radiology and of obstetrics and gynecology at Vanderbilt University School of Medicine; Dr. G. Leland Melson, associate professor of radiology at the Mallinkrodt Institute of Radiology and chief of diagnostic ultrasound at Washington University School of Medicine; and Dr. Thomas E. Sumner, associate professor of radiology and pediatrics at Bowman Gray School of Medicine.

Sessions include sonography of the placenta, a survey of small parts scanning, ectopic pregnancy, fetal anomalies and neonatal neurosurgery.

Dr. Sandra Rhoden, president of the Mississippi Ultrasound Society, is course coordinator. Dr. John Gibson, UMC associate professor of radiology and director of the division of ultrasound, is moderator for the afternoon session.

Course fee is \$125 for physicians; \$45 for sonographers. For information, contact Continuing Education, University Medical Center.

In 1979, when results were published for the five-year, 10,000-patient Hypertension Detection and Follow-up Program (HDFP study), which Step-2 regimen was preferred and was deemed effective without significant adverse effects?²



MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 13-17, 1982, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

State and Local

Mississippi State Medical Association, 114th Annual Session, May 2-6, 1982, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, June 30-July 3, 1982, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 3rd Wednesday, January, May, and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. J. Barry Gilbert, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Robert L. Coggin, Pres. and Secy., 965 Avent Dr., Grenada 38901. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, State, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March,

June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Albert H. Laws, Secy., 816 Second Ave. North, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, June, September, December. Robert D. Holbert, Secy., P.O. Box 1502, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Douglas F. Thomas, Secy., 415 South 28th Ave., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly
Mississippi State Medical Association
735 Riverside Drive
Jackson, MS 39216

North Mississippi Medical Center
830 Gloster Avenue
Tupelo, MS 38801

Forrest General Hospital
Box 1897
Hattiesburg, MS 39401

Mississippi Baptist Hospital
1225 N. State Street
Jackson, MS 39201

Gulf Coast Community/Gulfport
Memorial Hospital Consortium
4642 W. Beach Boulevard
Biloxi, MS 39531

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Delta Medical Center
Greenville, MS 38701

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Biloxi Regional Medical Center
1559 Lafayette St.
Biloxi, MS 39533

Mississippi Radiological Society
316 Medical Arts Building
Jackson, MS 39201

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

Mercy Regional Medical Center
100 McAuley Drive
Vicksburg, MS 39180

North Panola County Hospital
Drawer 160
Sardis, MS 38666

Singing River Hospital
2809 Denny Avenue
Pascagoula, MS 39567

Magnolia Hospital
Alcorn Drive
Corinth, MS 38834

Greenwood Leflore Hospital
1508 Leflore Avenue
Greenwood, MS 38930

South Washington County Hospital
Drawer 398
Hollandale, MS 38748

DEATHS

FALKER, JAMES B., Greenwood. Born Springfield, IL, Aug. 5, 1928; M.D., University of Illinois College of Medicine, Chicago, 1956; interned and ob-gyn residency, Cook County Hospital, Chicago, 1956-60; ophthalmology residency, Gulf States Eye Surgery Foundation and V. C. Smith Memorial Eye Clinic, New Orleans, 1968-70; ophthalmology residency, Mobile General Hospital, Mobile, AL, 1970-71; died Nov. 3, 1981, age 53.

LATHAM, WILBUR D., Jackson. Born Ludlow, MS, July 31, 1927; M.D., Tulane University School of Medicine, New Orleans, 1953; interned Mississippi Baptist Hospital, Jackson, 1953-54; surgery residency, U.S. Naval Hospital, Great Lakes, IL., 1957-60; plastic surgery, University of Illinois Hospital, Chicago, 1960-62; died Nov. 23, 1981, age 54.

NEW MEMBERS

BECKMAN, WILLIAM E., III, Jackson. Born Greenville, MS, Aug. 29, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned and ob-gyn residency, University Medical Center, Jackson, 1976-80; elected by Central Medical Society.

KAHLSTORF, JACK H., Tupelo. Born Greenville, MS, Jan. 16, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned and ob-gyn residency, University Medical Center, Jackson, 1977-81; elected by Northeast Mississippi Medical Society.

McVEY, ERIC A., III, Jackson. Born Memphis, TN, Jan. 6, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned Mayo Clinic, Rochester, MN, one year; medicine residency, same, 1977-79; infectious disease residency, same, 1979-81; elected by Central Medical Society.

In 1980, when the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure published their recommendations, which Step-2 regimen best met their criteria for effectiveness, safety, simplicity of titration, convenience, and economy?³



NEW MEMBERS / Continued

MESSER, THOMAS S., JR., Hattiesburg. Born New Iberia, LA, Dec. 16, 1949; M.D., University of Alabama School of Medicine, Birmingham, 1974; interned Baptist Memorial Hospital, Memphis, TN, one year; medicine residency, same, 1976-78; cardiology residency, Oschner Foundation, New Orleans, 1978-79; cardiology residency, Baptist Memorial Hospital, Memphis, 1979-81; elected by South Mississippi Medical Society.

MORRISON, CHARLES E., Columbus. Born Sept. 8, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned and urology residency, University Medical Center, Jackson, 1973-78; elected by Prairie Medical Society.

MORRISON, WINSOR V., Jackson. Born Zanoni, MO, Feb. 16, 1925; M.D., University of Tennessee College of Medicine, Memphis, 1957; interned USPHS, Seattle, WA, one year; general surgery residency, USPHS, Staten Island, NY, 1962-63;

otolaryngology residency, Washington University, St. Louis, MO, 1963-66; elected by Central Medical Society.

PACE, MARY E., Tupelo. Born Oxford, MS, Jan. 22, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned and medicine residency, University Medical Center, Jackson, 1975-78; elected by Northeast Mississippi Medical Society.

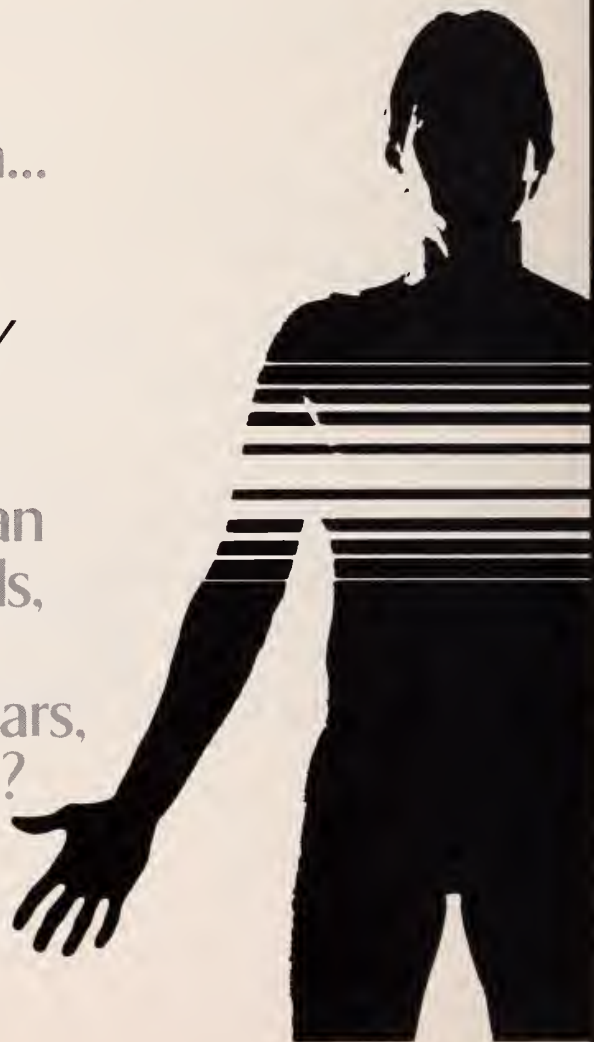
PARK, CHONG H., Jackson. Born Kwangfu, Korea, Feb. 6, 1948; Choong-nam National University Medical School, Taejon, Korea, 1973; interned Mt. Vernon Hospital, Mt. Vernon, NY, 1980; anesthesiology residency, New York University Medical Center, NY, 1977-78; anesthesiology residency, Beth Israel Medical Center, NY 1978-80; elected by Central Medical Society.

PROSSER, H. SIDNEY, Hollandale. Born Vicksburg, MS, Jan. 4, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned and family practice residency, University Medical Cen-

Believe it or not, doctor,
it's the combination found in...

Salutensin[®]
(hydroflumethiazide 50 mg/
reserpine 0.125 mg)

And don't the results of more than
\$100 million worth of clinical trials,
involving thousands of patients
who were followed for several years,
merit your serious consideration?



ter, Jackson, 1977-80; elected by Delta Medical Society.

REYES, CIRILA L., Waynesboro. Born Balengas, Philippines, July 5, 1942; M.D., College of Medicine, Manila Central University, Manila, Philippines, 1966; interned Misericordia Hospital, Philippines, one year; pediatric residency, Martland Hospital, Newark, NJ, 1974-76; pediatric residency, Jersey City Medical Center, NJ, 1976-77; elected by South Mississippi Medical Society.

ROBINSON, SAMUEL P., Gulfport. Born Shreveport, LA, Aug. 10, 1971; M.D., Tulane University School of Medicine, New Orleans, 1976; interned Maricops County General Hospital, Phoenix, AZ, 1976-78; otolaryngology residency, Tulane Medical Center, New Orleans, 1978-81; elected by Coast Counties Medical Society.

ROSS, JOE ROBINSON, Jackson. Born Greenwood, MS, July 30, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned Letter-

man Army Medical Center, San Francisco, one year; general surgery residency, University Medical Center, Jackson, 1977-78; urology residency, same, 1978-81; elected by Central Medical Society.

SANFORD, BENJAMIN F., JR., Starkville. Born Knoxville, TN, July 17, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned and medicine residency, University Medical Center, Jackson, 1977-80; elected by Prairie Medical Society.

SCHIMMEL, GEORGE B., Jackson. Born Vicksburg, MS, July 12, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned, medicine residency and cardiology fellowship, University Medical Center, Jackson, 1976-81; elected by Central Medical Society.

SHANNON, EUGENE L., Hattiesburg. Born Indianola, MS, March 22, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned Pensacola Educational Program, Pensacola, one year; ob-gyn residency, University Medical Center,

And there's more proof on the way!

1982 will see the completion of the Multiple Risk Factor Intervention Trial (MRFIT)—a six-year, 12,000-patient study assessing the factors that increase risk of cardiovascular disease. For the management of hypertension, the preferred Step-2 regimen in this study is reserpine-thiazide.

In 1978, in a preliminary report presented to the Epidemiology Section of the American Heart Association (Dallas, Nov 1978), after 12 months of the trial, fewer patients (5.3%) treated with reserpine suffered depression than even the untreated control group (7.7%)!

Please see references and brief summary of prescribing information on last pages of this advertisement.

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Please provide me with:

- ☐ Clinical samples of Salutensin® (hydroflumethiazide 50mg/reserpine 0.125mg) and Salutensin-Demi™ (hydroflumethiazide 25mg/reserpine 0.125mg)
- ☐ Journal article reprints of the clinical studies mentioned in this ad

Name (please print)

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State

Zip

Signature

CUT HERE—FILL OUT—CUT HERE—FILL OUT

SM-2348

11/81

NEW MEMBERS / Continued

Jackson, 1977-80; elected by South Mississippi Medical Society.

SHORT, DWIGHT H., II, Gulfport. Born Brooklyn, NY, May 31, 1939; M.D., University of Cincinnati College of Medicine, Cincinnati, 1967; interned, general surgery residency, surgical research fellowship and cardiac-thoracic surgery residency, Cincinnati General Hospital, Cincinnati, 1967-77; elected by Coast Counties Medical Society.

SMITH, E. ROSS, Philadelphia. Born Selmer, TN, Feb. 4, 1941; M.D., University of Tennessee College of Medicine, Memphis, 1966; interned City Memphis Hospital, Memphis, one year; pediatric residency, University Medical Center, Jackson, 1969-72; elected by East Mississippi Medical Society.

VOYLES, CARL RANDLE, Jackson. Born Ripley, MS, Apr. 25, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned University of Louisville Hospital, Louisville, KY, one year; surgery residency, same, 1976-80; fellowship, London, England, 1980-81; elected by Central Medical Society.



Tennis Deep Sea Fishing Golf

These tournaments are just a few of the special activities on the schedule for MSMA's 114th Annual Session.

Plan Now to Attend!

Salutensin® Salutensin-Demi™

(Hydroflumethiazide, Reserpine Antihypertensive Formulation)

Brief Summary of Prescribing Information (12) 10/27/78

For complete information consult Official Package Circular.

WARNING

This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

CONTRAINDICATIONS

Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

WARNINGS

Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or

without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients.

Use in Pregnancy

Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

PRECAUTIONS

Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia

(especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

PERSONALS

CORRECTION: There was an error in an announcement in the January issue. The statement should read, DONALD C. GUILD and ROBERT L. MCKINLEY, both of Jackson, announce the opening of their office for the practice of general and forensic psychiatry at 1900 Dunbarton, Suite B.

GENE BARRETT of Jackson presented "Acute Anteromedial Rotary Instability of the Knee" at the annual meeting of the American Academy of Orthopaedic Surgeons in New Orleans.

WILLIAM BATES of UMC was visiting professor at the University of Tennessee College of Medicine in Memphis.

MILAM S. COTTEN of Hattiesburg has been elected to a two-year term as a councillor of the Louisiana-Mississippi Ophthalmological and Otolaryngological Society.

C. RALPH DANIEL of Jackson has been certified as a diplomate of the American Board of Dermatology.

FRANK E. DEMENT, III announces the association of KIMBLE LOVE at Children's Clinic of Hattiesburg, P.A.

HENRY W. DEWITT, JR. of Laurel announces the association of JOYCE B. ROGERS for the practice of anesthesiology.

EDGAR DRAPER of UMC recently presented a workshop on pastoral care and counseling at Christ Hospital in Cincinnati.

CARL EVERS of UMC presented a paper at a meeting of the Group for Research in Pathology Education in San Antonio in January.

VERNER S. HOLMES received the Oliver Emmerich Award for Distinguished Service presented by the McComb Chamber of Commerce.

WILLIAM C. HOPPER, JR. of Gulfport recently was inducted as a fellow of the American Academy of Orthopaedic Surgeons.

JOHN F. JACKSON of UMC chaired a subsection at a recent meeting of the Southern Society for Clinical Investigation.

ADVERSE REACTIONS

Hydroflumethiazide

Skin-rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation.

Reserpine

Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares.

USUAL DOSE

1 tablet b.i.d.

SUPPLIED

Bottles of 100 and 1000 scored 50 mg. tablets.

References:

1. Propranolol in the treatment of essential hypertension. Veterans Administration Cooperative Study Group on Antihypertensive Agents. *JAMA* 237:2303-2310, 1977.
2. Five-year findings of the hypertension detection and follow-up program: I. Reduction in mortality of persons with high blood pressure, including mild hypertension. Hypertension Detection and Follow-up Program Cooperative Group. *JAMA* 242:2562-2571, 1979.
3. The 1980 Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med* 140:1280-1285, 1980.

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Syracuse, New York 13201

PERSONALS / Continued

JOSEPH E. JOHNSTON of Mount Olive has been appointed to the Commission on Education of the American Academy of Family Physicians.

RODNEY MEEKS of UMC was a visiting professor at Memorial Medical Center in Savannah, GA.

L. R. MURPHREE of Aberdeen announces the association of J. C. CHAUVIN for the general practice of medicine.

NORMAN NELSON of UMC was guest speaker for the scientific session of the Rapides Parish Medical Society Founders Day in Alexandria, LA.

JOE NORMAN and WILLIAM PINKSTON of UMC were among program participants at the tri-state meeting of the Mississippi Thoracic Society in Biloxi.

RON POWELL of West Point spoke on the subject of hypertension at the West Point Rotary Club.

ROBERT N. SUARES of Greenville has been inducted a fellow of the American College of Surgeons.

EDWARD TURNBULL of Laurel was inducted as a fellow of the American Academy of Orthopaedic Surgeons at the annual meeting in New Orleans.

W. LAMAR WEEMS of UMC was visiting professor at the National Naval Medical Center and at Walter Reed Army Medical Center, and was speaker for the "Distinguished Speaker Series" at Uniformed Services University of the Health Sciences in January.

H. A. WHITTINGTON of Natchez received an engraved Abbott Golden Timepiece from Abbott Laboratories in recognition of his 53 years of service in the practice of medicine.

WINFRED WISER of UMC was among guest lecturers for the Pan Pacific Surgical Society assembly in Honolulu.

MISSISSIPPI STATE MEDICAL ASSOCIATION

114th Annual Session

BILOXI, MISSISSIPPI
BILOXI HILTON
MAY 2-6, 1982



A COMPLETE MEETING

- 14 Scientific Sections
- Specialty Society Meetings
- Scientific Exhibits
- Alumni Reunions
- Auxiliary Activities
- House of Delegates
- Tennis, Golf, Fishing
- 125th Anniversary Party



In Vertigo

On Balance...

RU-VERT[®]

Each Tablet Contains:

Pentylenetetrazol.	25.0 mg
Pheniramine maleate.....	12.5 mg
Nicotinic acid.	50.0 mg

Clinically proven actions

- Antihistaminic
- Cerebral stimulant
- Vasodilator

Few side effects

- Vasodilation occasionally causes facial flushing which can be minimized by recommending that Ru-Vert[®] be taken following meals or with food.

Dosage

- One or two tablets three times a day

Please see next page for a summary of prescribing information

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In Vertigo On Balance... **RU-VERT®**

See following prescribing information.

DESCRIPTION: Each tablet contains the following active ingredients:

Pentylenetetrazol	25.0 mg
Pheniramine maleate	12.5 mg
Nicotinic acid	50.0 mg

INDICATIONS: Ru-Vert is indicated as an adjunct therapy in the symptomatic treatment of acute or chronic vertigo.

CONTRAINDICATIONS: Convulsive disorders or known history of sensitivity to any of the listed active ingredients. Because of the vasodilating action of nicotinic acid, Ru-Vert should not be used in patients with hypotension.

WARNINGS: The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS: Although there are no absolute contraindications to pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of Ru-Vert who have heart disease. While pentylenetetrazol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

Pheniramine maleate, like other antihistamines, may produce sedative side effects in certain patients.

Transient vasodilatation due to rapid absorption of nicotinic acid may produce facial flushing and a sensation of warmth. These effects may be ameliorated by recommending that Ru-Vert be taken following meals or with food.

ADVERSE REACTIONS: Pentylenetetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylenetetrazol.

DRUG ABUSE: Drug dependence has not been reported with Ru-Vert.

OVERDOSEAGE: Signs and symptoms of acute overdose may be due primarily from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures. If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage.

Intensive care must be provided to maintain adequate circulation and respiratory exchange.

DOSEAGE AND ADMINISTRATION: The recommended dosage of Ru-Vert for vertigo or motion sickness is 1 or 2 tablets three times a day with meals or light snacks.

This drug is not for use in children under 12 years of age.

HOW SUPPLIED:

Bottles of 100 tablets

Bottles of 300 tablets

Federal law prohibits dispensing without prescription.

NOC 0524-0060-01

NOC 0524-0060-03

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RECOLLECTIONS

Ten years ago the March 1972 issue of JOURNAL MSMA carried news of the association's upcoming 104th Annual Session in Biloxi. Dr. Raymond F. Martin, Jr. of Jackson, chairman of the Council on Scientific Assembly, announced that for the first time the scientific program would include some 12 hours of presentations broadcast via inhouse television at the host hotel. Designed to supplement the live scientific sessions, the innovative programming had been secured through the AMA's Department of Communications, he reported.

According to the editorial page of that issue, chiropractic legislation was a topic of discussion at Mississippi's Capitol, with a bill under consideration which, according to the editorial, would "regulate" chiropractic and institute a program of licensure. The writer remarked that licensure would make chiropractors immune to prosecution for violation of the medical practice act and predicted that "once licensed, it would only be a matter of time until the amendments come for inclusion under workmen's compensation, health insurance, Medicaid, and any other health service subject to state law."

Scientific articles in the 1972 issue included: "Tuberculosis of the Wrist," by Dr. Edward L. Gieger, Jr. of Jackson; "Use of Drugs Under the Mississippi Medicaid Program," by Dr. Alton B. Cobb et al; and "The Shock Lung: Pathogenesis and Treatment," by Drs. Watts R. Webb, Stennis D. Wax, and T. Murakami of Syracuse, NY.

Twenty years ago in the March 1962 issue of JOURNAL MSMA, Dr. William E. Lotterhos of Jackson, chairman of the association's Council on Legislation, reported progress on the MSMA-sponsored "Good Samaritan," bill. The bill had passed the House and was under consideration by a Senate committee. At that time, eight states in the nation had passed such laws and four other state legislatures were studying proposed bills.

Scientific articles in the 1962 issue included: "Antihypertensive Drugs: A Controlled Evaluation," by Drs. Raymond F. Grenfell, Arthur H. Briggs, and William A. Holland of Jackson; "Infected Abortions," by Dr. Warren C. Plauche of Jackson; "Histoplasmosis: A Review With Case Reports," by Dr. T. S. McCay of Belzoni; and "Closure of Traumatic Wounds of the Hand," by Dr. J. D. Davis of Corinth.

JOURNAL MSMA

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*Reference: 1981-82 American Druggist Blue Book

SU-TON[®]

Liquid Tonic

A Tonic for Geriatric Patients

A pleasant tasting tonic containing iron, vitamins, minerals, and an analeptic. Ideal for those who may benefit from vitamin deficiency prevention. Just one tablespoon before each meal.

DESCRIPTION Forty-five milliliters of SU-TON contains the following ingredients: Pentylenetetrazol, 30 mg • Niacin, 50 mg • Vitamin B-1, 10 mg • Vitamin B-2, 5 mg • Vitamin B-6, 1 mg • Vitamin B-12, 3 mcg • Manganese (as Manganese Sulfate), 1 mg • Magnesium (as Magnesium Sulfate), 2 mg • Zinc (as Zinc Sulfate), 1 mg • Iron (as Ferric Pyrophosphate, Soluble), 22 mg • Alcohol, 18%
INDICATIONS AND USAGE SU-TON contains pentylenetetrazol which may be helpful in the older patient as an analeptic agent when mental confusion and memory defects are present. SU-TON also contains vitamins, trace minerals, and iron, for those patients who may benefit by preventing the development of a deficiency.

CONTRAINDICATIONS Epilepsy, convulsive disorders or known history of sensitivity to any of the listed active ingredients.

WARNINGS The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS Although there are no absolute contraindications to pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of SU-TON who have heart disease. While pentylenetetrazol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

ADVERSE REACTIONS Pentylenetetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylenetetrazol.

DRUG ABUSE Drug dependence has not been reported with SU-TON.

OVERDOSAGE Signs and symptoms of acute overdose may be due principally from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures. If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage. Intensive care must be provided to maintain adequate circulation and respiratory exchange.

DOSAGE AND ADMINISTRATION One tablespoonful (15 ml) 3 times a day 20-30 minutes before meals. This drug is not for use in children under 12 years of age.

HOW SUPPLIED Bottles of 473 ml (16 fl. oz.)

Federal law prohibits dispensing without prescription.

NDC 0524-1015-16

February 1982

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DR. COLLINS ISN'T PAYING HIS MALPRACTICE INSURANCE PREMIUM THIS YEAR.

But he'll still be covered. Because the Army covers it. Jack Collins is an Army surgeon. And he doesn't have to burden himself with the details of running a civilian surgical practice. The Army does the worrying for him.

It works out better for Dr. Collins. And for the Army. He has a relatively trouble free practice. And the Army has a first-rate surgeon.

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Every Army surgeon is commissioned as a Captain or higher. He earns 30 days paid vacation a year. And his noncontributory retirement benefits are substantial.

Jack Collins joined the Army to practice surgery. . .not bookkeeping, typing, accounting, or hiring office help. Army medicine is as free from nonmedical distractions as it is possible for any practice to be.

The Army Medical Department has positions available or projected requirements for physicians trained in the following specialties in the Southeastern United States:

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SURGEON seeks location in general thoracic and cardiac surgery upon completion of residency in July, 1982. Graduate of Tulane University, 1975. Contact Dr. Kevin M. Keubler, 600 Highland Ave., Madison, WI 53792.

PHYSICIAN completing radiology residency in June 1982 seeks location with private community hospital. Graduate of Harvard. Contact Dr. Eugene B. Rosenberg, Mount Sinai Medical Center, 4300 Alton Road, Miami Beach, FL 33140.

PHYSICIAN completing pathology residency in September 1982 seeks location with pathology group with emphasis on surgical pathology. Graduate of University of Tennessee School of Medicine. Contact Dr. William D. Crump, 1027-B Beacon Parkway East, Birmingham, AL 35209.

PHYSICIAN completing pathology residency in June 1982 seeks group or partnership. Graduate of University of Mississippi School of Medicine. Contact Dr. Walton L. Moore, Department of Pathology, University of Alabama, Birmingham, AL 35294.

PATHOLOGIST especially interested in coagulation and blood banking seeks hospital-based position. Contact Daniel Williams, Jr., M.D., 77 Rippowam Rd., Apt. A, Stamford, CT 06902.

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BOARD ELIGIBLE INTERNIST seeks practice location; M.D. from University of Texas at Southwestern. Contact Stephen R. Cherry, M.D., 7061 B Creekview Trail, St. Louis, MO 63123.

BOARD ELIGIBLE PATHOLOGIST seeks practice opportunity. Graduate of University of Mississippi School of Medicine; residencies, UMC. Contact Marianna G. Pardue, M.D., 315 Cedarwood, Jackson, MS, 39212.

BOARD CERTIFIED FAMILY PRACTITIONER seeks practice location. Currently completing military obligation and available 7/82. Contact John E. Bailes, Jr., M.D., 5405 Hackney Circle, Bossier City, LA 71111.

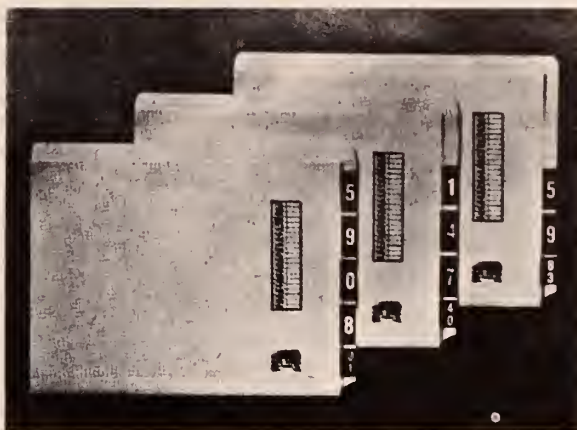
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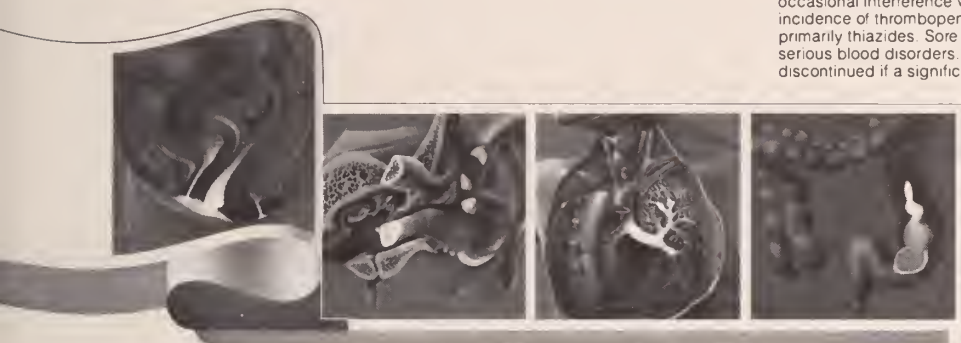
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faster relief of diarrhea than with ampicillin²

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonia. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: General: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema

multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age. URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) *b.i.d.* for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) *b.i.d.* for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose[®] packages of 100; Prescription Paks of 20 and 28. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose[®] packages of 100, Prescription Paks of 40. Pediatric Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).



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1. Rubin RH, Swartz MN: *N Engl J Med* 303:426-432, Aug 21, 1980. 2. Data on file, Medical Department, Hoffmann-La Roche Inc.

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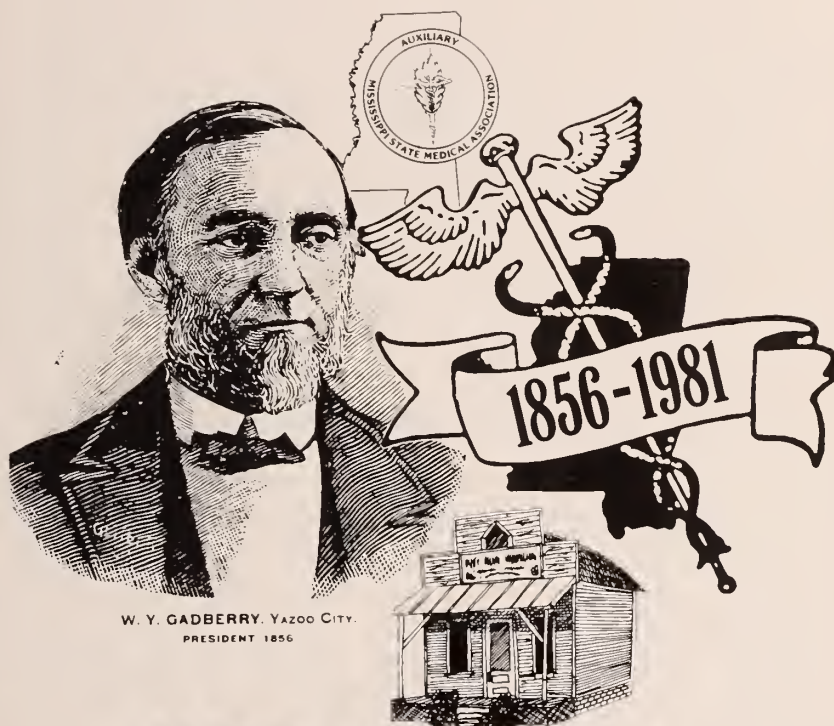
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* due to susceptible strains of indicated organisms

Please see previous page for summary of product information.

April 1982

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ONE OF THE VITAL SIGNS OF ANXIOUS DEPRESSION: INSOMNIA

Others to look for:

agitation
anorexia
feelings of guilt
and worthlessness
fatigue
palpitations
headache
vague aches
and pains
sadness
psychic and
somatic anxiety

Artist's conception,
looking out from the human eye
as conceived in a schematic model.



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Many patients respond readily to a single bedtime dose of Limbitrol, a convenient schedule that may enhance compliance and helps relieve the insomnia associated with anxious depression. Limbitrol also offers a choice of other regimens: t.i.d., or a divided dose with the larger portion h.s. In all cases, caution patients about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as driving or operating machinery.

in moderate depression and anxiety

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Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline
(as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline
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Specific therapy with h.s. dosage convenience

Please see summary of complete product information on following page.

LIMBITROL® TABLETS Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, oppression, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks of 50.

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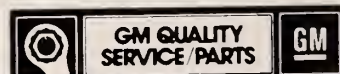
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The cover of this issue features artwork which was designed for a limited edition, commemorative plate rendered for the Mississippi State Medical Association in recognition of the association's 125th anniversary. Plates will be available for purchase at the 114th Annual Session, May 2-6, in Biloxi.

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1. Ginsburg CM, McCracken GH Jr, Zweighaft TC, Clahsen JC: Comparative pharmacokinetics of cyclacillin and amoxicillin in infants and children. *Antimicrob Ag Chemother* 19:1086-1088 (June) 1981.

2. Multicenter trials. Data to be published.

See important information on page after next.

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Faster peak. Fewer problems.

... in adults and children

Cyclapen®-W (cyclacillin) produces peak serum concentrations* almost four times higher and over one hour earlier.³

Cyclapen®-W is just as effective in otitis media, bronchitis, pneumonia, urinary tract infections and infections of skin and skin structures†.³

Cyclapen®-W produces a significantly lower incidence of diarrhea and skin rash.³

CYCLAPEN®-W
(cyclacillin) Tablets/Suspension

Rapid onset of action with fewer side effects.

*Rapidly excreted unchanged in urine.

Clinical efficacy may not always correlate with blood levels.

†Due to susceptible organisms.

3. Data on file, Wyeth Laboratories.

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See important information on adjoining page.

Wyeth Laboratories
Philadelphia, Pa 19101



Cyclapen®-W (cyclacillin)

Indications

Cyclacillin has less *in vitro* activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacterium. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment of least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.

†depending on severity

How Supplied Tablets 250 mg and 500 mg in bottles of 100. Oral Suspension 125 mg and 250 mg per 5 ml in bottles to make 100 ml and 200 ml of Suspension.

Wyeth Laboratories
Philadelphia, Pa 19101

LEVERAGED

MANAGED ACCOUNT SERVICE

Conti New Orleans — Offers a great variety of services to a group of clients who invest in the very specialized area of commodity futures. We do not believe in the Financial Super Market concept, simply because we are convinced that you cannot be good at everything. Commodities are **our only business**.

In our continuing efforts to be the standard by which others are measured, Conti New Orleans offers several managed account programs that may be of interest. For example, our trading program in foreign currencies has been a **Spectacular Success**. To find out more about these managed programs, please contact.

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*Doug May
1080 River Oaks Drive
Suite A-104
Jackson,
Mississippi 39208*

NEWSLETTER

April 1982

Dear Doctor:

A brochure on medical quackery published by the Federal Postal Inspection Service warns that "today's quacks are highly sophisticated salespeople who use widespread deceptive advertising to offer 'miracles' they can't produce." Physicians may want to obtain a copy for duplication for patients. Write to Chief Postal Inspector, Consumer Protection Program, Washington, DC, 20260 for the brochure entitled "Do You Believe in Magic?"

The booklet includes a postage-paid card for reporting suspected cases of medical fraud. The brochure states four warnings: don't trust your health to a salesman; don't believe claims of a secret cure or miracle drug; don't believe claims of excessive weight loss; and don't believe exaggerated claims of regained youth.


The U.S. Supreme Court has agreed to review a case involving the issue of whether generic drugs can be sold before they are reviewed by the FDA. The Fifth Circuit Court of Appeals has ruled that prior approval applies only to the active ingredients of a product, while the FDA argues that potentially harmful inactive ingredients warrants agency review of generic drugs.

More physicians today than in 1978 know how to perform cardiopulmonary resuscitation, according to a recent survey by the American Medical Association. More than 90% of physicians have had training in the currently accepted CPR procedures. Nearly three-fourths of physicians responding to the questionnaire favor mandatory CPR training for physicians.

Personal spending has undergone considerable change since 1941, according to a December news report. Share of outlays for food and beverages dropped from 23.7% in 1941 to 18.1% in 1981. Drops were recorded for alcohol (5.1% to 2.6%) and clothing (13.0% to 7.4%). Increases were in housing (12.9% to 16.3%), transportation (10.6% to 14.5%) and medical care (10.6% to 14.5%).

Room reservation cards have been mailed to MSMA members for housing at the Biloxi Hilton, host hotel for the 114th Annual Session, May 2-6. This issue contains articles describing the many scientific sessions, specialty society meetings, fellowship and sports occasions, and association business sessions. See you in Biloxi for the annual session and for MSMA's 125th anniversary celebration!

Sincerely,



Patsy Silver
Managing Editor

DRAMATIC NEW CLINICAL PROOF*

In the treatment of impetigo—

- **100% cure rate with Tegopen®** (cloxacillin sodium)
- **only a 60% cure rate with penicillin V-K**



As seen on admission



After one week of penicillin V-K therapy



Two weeks after initiation of TEGOPEN therapy

Treatment failure was judged to have occurred when lesions increased in size and/or number during the initial week of treatment with penicillin V-K. No treatment failures occurred with Tegopen.

*Data on file, Bristol Laboratories.

Brief Summary of Prescribing Information

TEGOPEN®
(cloxacillin sodium)
Capsules and Oral Solution

For complete information, consult Official Package Circular.

(12) 9/11/75

INDICATIONS:

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

RESULTS OF ORAL THERAPY revealed a high percentage of treatment failures with penicillin V potassium, but *no* failures with Tegopen.

		Given Tegopen® (cloxacillin sodium)	Given penicillin V-K
<i>Staphylococcus aureus</i>	(78 patients)	39	39
Returned to clinic at one week		29†	38†
Treatment failure at one week		0	18 (47.4%)
<i>Staphylococcus aureus</i> and <i>Streptococcus pyogenes</i>	(9 patients)	4	5
Returned to clinic at one week		4	5
Treatment failure at one week		0	2 (40%)
No initial bacterial growth	(14 patients)	9	5
All 14 healed, regardless of which antibiotic was administered.			
Beta-hemolytic <i>Streptococcus</i>	(1 patient)	0	1
TOTALS:	102 patients	52 patients	50 patients

†Eleven patients did not return for their one-week checkup. These were all called by telephone, and their families reported

the lesions had healed. One patient was dropped from the study, early, because of adverse reaction to medication.

STUDY: DESCRIPTION/PROTOCOL

- 102 nonselected subjects, with initial bacteriology as follows: 77% *Staphylococcus aureus*, 9% mixed *Staphylococcus aureus* and *Streptococcus pyogenes*, and 1% beta-hemolytic *Streptococcus*.†
- All patients were given randomized therapy—Tegopen capsules or oral solution, or penicillin V-K tablets or oral solution, in recommended dosages according to body weight.

- All patients were evaluated after one week's therapy. If there was no improvement, therapy was switched to the other antibiotic. The "other antibiotic" proved to be Tegopen 100% of the time because no treatment failures had occurred with Tegopen.
- A final assessment of progress was made two weeks after initiation of Tegopen therapy.

†The remainder, to equal 100%, consisted of 14 patients (13%) who exhibited no initial bacterial growth. These 14 were all healed, whether given Tegopen or penicillin V-K.

TEGOPEN®

(cloxacillin sodium)

**-effective therapy for staph infections
of the skin and skin structures**

WARNING:

Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

PRECAUTIONS:

The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:

Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose

stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:

Adults: 250 mg. q. 6h.

Children: 50 mg./Kg./day in equally divided doses q. 6h. Children weighing more than 20 Kg should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS

SUPPLIED:

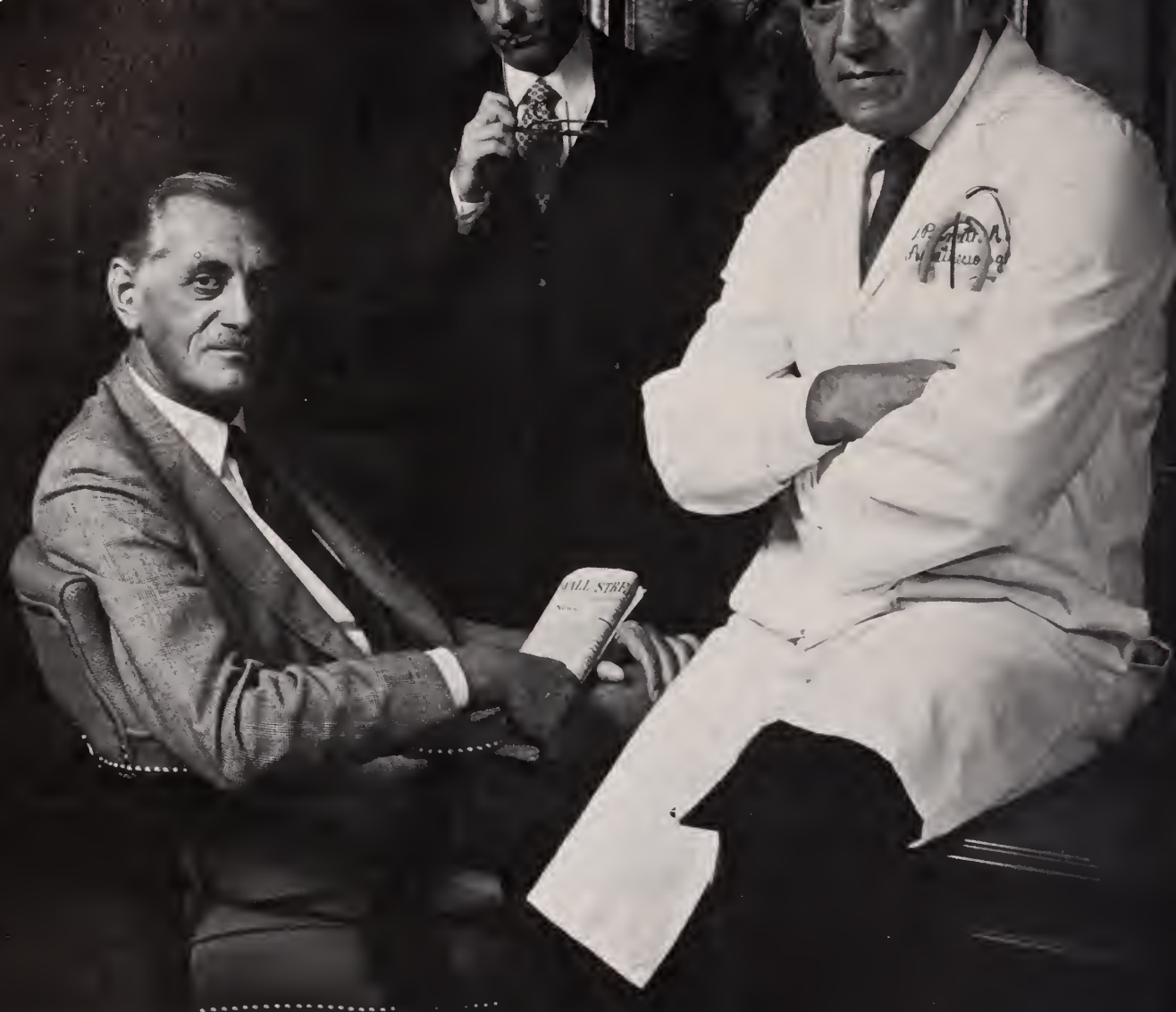
Capsules—250 mg. in bottles of 100. 500 mg. in bottles of 100.
Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

BRISTOL®

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Division of Bristol-Myers Company
Syracuse, New York 13201

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One of these men has a problem...



and so do his family and colleagues.

There are special considerations in the treatment of professionals and executives who are impaired through dependency on drugs or alcohol: not because the patient or his addiction is different from others, but because of the strict sanctions imposed by the public and professional communities.

The A & D Center specializes in the treatment of the professional or executive who is chemically dependent. Treatment at the Center is designed to provide complete medical and counseling services, with care, dignity, and confidentiality for the patient. Family care and aftercare are emphasized, and specific plans are made for the re-entry process.

The A & D Center, located at the modern, 162-bed Doctors Hospital in Jackson, offers a 96-hour evaluation program, with the total inpatient treatment program extending for thirty days. For further information on the A & D Center, contact:



Doctors Hospital A & D Center
2969 University Drive
Jackson, Mississippi 39216
(601) 982-8321

DATELINE

Governor Signs Optometry Bill

Jackson, MS - Last month Governor Winter signed into law H.B. 475, which authorizes optometrists to use pharmaceutical agents for diagnostic purposes. In his message to the House which accompanied his approval of the bill, the Governor stated that he had signed the bill "only after the most intensive deliberation and with some reservations about the effect of this legislation." He also noted that the bill contains an automatic repealer on July 1, 1985.

High Employment In Health Services

Jackson, MS - Statistics from the Mississippi Employment Security Commission indicate that more than 35,000 people were employed in health services in the state during December 1981. This total was exceeded only by the number employed in government, finished textile products, wholesale/retail trade, and construction. Average weekly earnings were: textile employees, \$148.75; non-supervisory bank employees, \$184.56; factory production workers, \$241.10.

Library Service For Blind Patients

Jackson, MS - Physicians who treat patients who are blind, visually impaired or physically handicapped, or who have a reading disability resulting from organic dysfunction, are encouraged to inform those patients of a free talking book library service. The service appears to be under-utilized because eligible persons are unaware of the program. For information, patients may be referred to the Mississippi Library Commission, P.O. Box 3260, Jackson, MS 39207.

Report on Nursing Home Facilities

Jackson, MS - The Mississippi Health Care Commission indicates in a recent report that the number of licensed nursing home facilities in 1980 totalled 176, with 14,215 beds. The majority (71.6%) were proprietary in ownership, and accounted for more than 77% of all beds. In contrast, 22.2% of the facilities were publicly owned, accounting for over 17% of all beds. Occupancy rate was 95.3%. Medicaid was the source of payment for more than 78% of the patients.

AMA Offers Video CME Courses

Chicago, IL - More than 50 hours of Category 1 CME credit are now available through the 18 programs offered by the AMA Video Clinic Library. "Common Skin Disorders: The Office Approach" is the latest of these in-depth courses designed for individual or small group study in the home, office or hospital. The clinics are two-to-six hour courses consisting of a color video tape, illustrated study guide, and self-assessment tests. The clinics are available for purchase or rent.

**When painful spasm
is the presenting
symptom...**

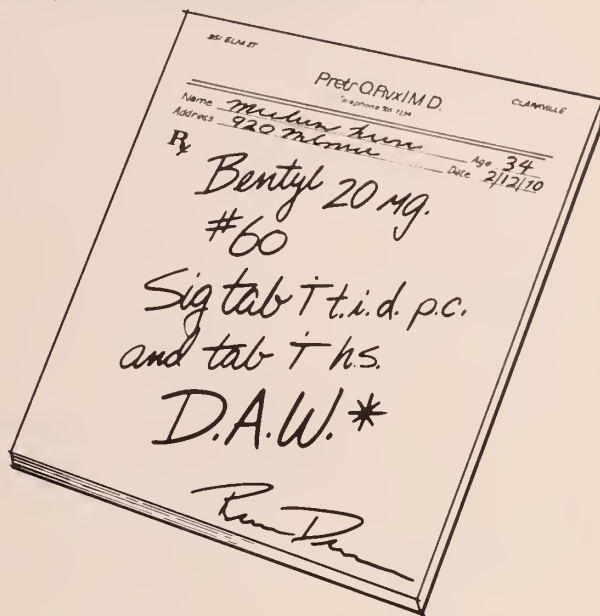


...in the functional bowel/irritable bowel syndrome*

be sure to specify

Bentyl[®]
(dicyclomine hydrochloride USP)

10 mg capsules, 20 mg tablets,
10 mg/5 ml syrup, 10 mg/ml injection



**D.A.W.-Dispense as written*

because:

- ⊕ The Bentyl molecule is a product of original Merrell research.
- ⊕ At Merrell Dow, Bentyl must go through 140 checkpoints/tests from its synthesis through the packaging of the final product.
- ⊕ Bentyl bioavailability of tablets, capsules, syrup and injectable is evidence of its prompt absorption.
- ⊕ Bentyl helps control abnormal gastrointestinal motor activity with minimal anticholinergic side effects. (See Warnings, Contraindications, Precautions, and Adverse Reactions on next page.)
- ⊕ The bioequivalence of the oral dosage forms permits a choice of tablet, capsules, or syrup that satisfies patient's dosage preferences.
- ⊕ Significant pharmacologic effect in the distal colon compared to placebo,¹ shows how Bentyl controls abnormal motor activity in the irritable colon patient.*

*This drug has been classified "probably" effective for this indication.

Merrell Dow

Reference:

1. Chowdhury AR and Lorber SH: Personal communication, 1980.

(See Product Information on the next page before prescribing Bentyl.)

Although the dose of Bentyl used to show pharmacologic effect was 50 mg, which is a higher single dose than that permitted in the labeling, the dose was considered justified, since the recommended daily dose of injectable Bentyl is 20 mg (2 ml) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg I.M. and, at that time, as a result of the sustained plasma levels from the 20 mg injections at 0 and 4 hours, might show an even higher plasma level than occurs after a single 50 mg dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection
AVAILABLE ONLY ON PRESCRIPTION
Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FOA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of light-headedness and occasionally local irritation.

DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonful syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (Dilute with equal volume of water.)

Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily.

Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only.

NOT FOR INTRAVENOUS USE.

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of July, 1980

Injectable dosage forms manufactured by

CONNAUGHT LABORATORIES, INC.

Swiftwater, Pennsylvania 18370 or

TAYLOR PHARMACAL COMPANY

Ocaturo, Illinois 62525 for

Merrell



MERRELL DOW PHARMACEUTICALS INC.

Subsidiary of The Dow Chemical Company

Cincinnati, OH 45215 U.S.A.

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It all adds up,

in today's major hypertension studies

VA Study¹

- 450 patients studied
- Mild to moderate hypertensives
- Comparison of propranolol and reserpine for Step-2 antihypertensive therapy
- **Conclusion:** when added to a thiazide diuretic, reserpine was effective in a larger percentage of patients (88%) than was propranolol (81%)!

HDFP Study²

- More than 10,000 patients studied
- Conducted at 14 centers over 5 years
- Proved that compliance with Step Care lowers death rate from all cardiovascular causes
- **Conclusion:** reserpine-thiazide regimens were *preferred* for Step-2 therapy, and were deemed effective, without significant adverse effects!

MRFIT Study³

- 6-year, 12,000-patient study, to be completed in 1982
- Assesses factors that may increase risk of cardiovascular disease
- Preferred Step-2 regimen: reserpine-thiazide
- **Full year's data:** reserpine is causing less depression than methyldopa, diuretics, or placebo!

That's why the combination in

Salutensin[®]
(hydroflumethiazide 50 mg/
reserpine 0.125 mg)

Is the preferred Step-2 regimen

Please see references and brief summary of prescribing information on adjacent page.

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BRISTOL[™]

Bristol Laboratories
Division of Bristol-Myers Company
Syracuse, New York 13201

Salutensin[®]
(hydroflumethiazide 50 mg/reserpine 0.125 mg)

Salutensin-Demi[™]
(hydroflumethiazide 25 mg/reserpine 0.125 mg)

Brief Summary of Prescribing Information (12) 10/27/78
For complete information consult Official Package Circular

WARNING

This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

CONTRAINDICATIONS

Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

WARNINGS

Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients.

Use in Pregnancy—Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

PRECAUTIONS

Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy.* Serum ammonia elevation may precipitate coma in premenstrual hepatic cirrhosis. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

ADVERSE REACTIONS

Hydroflumethiazide—Skin-rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation.

Reserpine—Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares.

USUAL DOSE

The usual adult dose of Salutensin is one tablet once or twice daily. If a smaller amount of thiazide diuretic is desired, Salutensin-Demi, one tablet once or twice daily can be given.

SUPPLIED

Bottles of 10 and 1000 scored tablets.

REFERENCES

1. Propranolol in the treatment of essential hypertension. Veterans Administration Cooperative Study Group on Antihypertensive Agents. *JAMA* 237:2303-2310, 1977.
2. Five-year findings of the hypertension detection and follow-up program. I. Reduction in mortality of persons with high blood pressure, including mild hypertension. Hypertension Detection and Follow-up Program Cooperative Group. *JAMA* 242:2562-2571, 1979.
3. Moser M, Kaplan NM, Sullivan JM, Paul O, in discussion: Perspectives on MRFIT. Can the interim data be applied to your practice...? An Interim Report on the Ongoing Multiple Risk Factor Intervention Trial: MRFIT. *New Perspectives on Hypertension* 2(1):10-19, February 1981.

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ORIGINAL PAPERS

Microglioma

ANUPAM ROUTH, M.D., J. KAPP, M.D., E. E. SMITH, M.D. and B. T. HICKMAN, M.D.
Jackson, Mississippi

MICROGLIOMA OF THE BRAIN is a rare tumor. This is the first case seen in the radiotherapy department at the University of Mississippi Medical Center.

The first reported case of a brain tumor of reticuloendothelial origin is by Bailey¹ in 1929. Yuile² first used the term reticular cell sarcoma of the brain. Yuile stated that the cell of origin is *Microglia*.

A semantic controversy has developed over the name of the neoplasm.³ The British like to use the term microglioma and Americans like to use the term reticulum cell sarcoma.

Armed Forces Institute of Pathology (AFIP) has introduced a new terminology, reticulum cell sarcoma-microgliomatosis.⁴ Polak,⁵ after reviewing 49 cases states, "We do not accept the existence of brain reticulosarcoma (non-argentophilic) and microgliomas (argentophilic) as different blastomatosis origin." We have recently seen a case of microglioma of the brain, which we report in this article.

Case History

The patient's history was obtained from her son and her husband because the patient had problems with her memory. Until Christmas 1980, the patient was doing fine and had no complaints. On Christmas Day of 1980, the patient complained that she was not feeling well. Initially she thought she had the flu. Generally, she was a very active person, but she just laid on the couch the whole day. Gradually her condition worsened. Approximately on the tenth day, her husband noticed his wife was having difficulty in spelling her own name. He immediately contacted the local doctor. The local doctor did a

thorough check-up and admitted her into the hospital. She stayed there for nine days and her condition worsened. She lost her memory completely and became dysphasic and hemiparetic on the right side. The local doctor suggested that she consult a psychiatrist as he could not find evidence of organic disease. The patient was seen by a neurologist, and a CT scan (see Figure 1) was obtained which showed a large enhancing tumor in the left posterior frontal area with extension across the midline in the genu of the corpus callosum. An angiogram showed a large hypovascular mass in the left frontal region. Preoperative diagnosis was a glioblastoma multiforme.

During the preoperative period, she rapidly became more obtunded, totally aphasic, and hemiplegic on the right side. The day prior to operation she again developed fever. At left frontal craniotomy, the tumor mass presented on the cortical surface as an area of reddish granular subpial tissue about 3 cm in diameter. The margin of this area was coagulated and a transcortical incision was made. Several large fragments of the tumor were removed and sent to pathology. The remainder of the core of the neoplasm was removed with suction. All gross tumor was removed to normal appearing brain. However, resection was not carried past the area of obvious gross tumor. The lateral ventricle was not entered. No attempt was made to remove the tumor from the right hemisphere. The final histology was returned as microglioma.

Pathology

Microscopic examination (see Figure 2) of the tissue removed from the left frontal lobe in sections stained with hematoxylin and eosin and for reticulum disclosed an extremely cellular malignant neo-

From the Department of Radiology, University Medical Center, Jackson, MS

plasm containing scattered foci of hemorrhage and necrosis. The tumor consisted mostly of diffuse sheets of small to medium, densely-packed cells having scanty, slightly eosinophilic, cytoplasm and indistinct cell borders. The relatively large vesicular nuclei of the cells were oval to polygonal and contained one or more prominent nucleoli. Mitoses were frequent. In some of the tissue fragments leptomeninges thickened by extensive tumor invasion covered the outlines of cortical gyri nearly completely replaced by tumor. At a number of sites blood vessels were encircled by broad cuffs of tumor cells associated with characteristically increased reticulin fibers. The tumor at its margins was poorly circumscribed and infiltrative, and a zone of reactive astrogliosis was present in the immediately adjacent brain tissue. The histologic features of the tumor were felt to be typical of a microglioma or reticulum cell sarcoma.

The patient started radiotherapy one week after surgery. She received a course of 5000 rads over five weeks. The patient received remarkable improvement. She regained her speech and had full strength and control of her right arm and leg, and was fully alert and oriented. After two months the patient returned for a follow-up visit. She was able to walk to the department. The neurological examination was entirely normal. The patient's speech was intact. There was no motor weakness and no complaints of headaches.

Incidence

This is a rare tumor. AFIP contain records of 1,450,000 cases of all type of which 11,712 are of M. Lymphoma. There are 83 cases of reticulum cell sarcoma-microgliomatosis in the record of AFIP.⁶ The biggest series are reported by Burstein⁷ of 41 cases; Henry et al,⁸ 83 cases; Littman et al, 19 cases; and Adams, 12 cases.

Jellinger from Budapest reported 68 cases out of 800 intracranial neoplasm. This gives the incidence 0.85% of all brain tumors. Reznik from Belgium reported nine cases in 6000 consecutive autopsies.

The age of the patient in which this disease occurs is fairly consistent in all the big series authors reviewed. This disease is common in patients between 50-55 years of age.

Duration of illness before diagnosis is made is generally similar to all the series. The period varies between 2-3 months.

Henry divided the symptoms into four categories: (1) increased intracranial pressure — 35%; (2) deficits in higher cortical functions such as dementia,



Figure 1. CT scan showing the tumor in left hemisphere.

psychiatric manifestations and reduced level of consciousness — 35%; (3) neurologic deficiencies including a variety of localizing and lateralizing signs referable to cranial nerves, muscle strength, sensation, and reflex status — 42%; and (4) seizure disorders — 10%. Many of the patients have symptoms belonging to more than one category.

One of the interesting features is the occurrence of microglioma in renal transplant patients.⁹ One of the patients reported by Henry had renal transplant.

Cerebrospinal fluid is abnormal in many patients. In the series from AFIP, 35 patients out of 41 patients who had CSF examination had abnormal CSF.

Jellinger noted the location of the tumors. They are located as follows:

- a. Cerebral Hemisphere, 41.2%
- b. Bilateral lesion, 8.6%
- c. Basal, 17.7%
- d. Multifocal, 22%
- e. Posterior fossa, 10.5%

Henry noted unifocal disease in 56% cases and multifocal disease in 44%. The most common site in

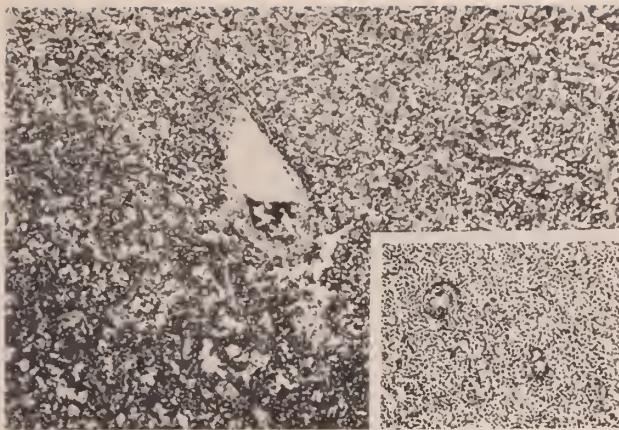


Figure 2. Inset showing reticulin stain preparation. Magnification 100x.

his series was also cerebrum. Ebels noted four cases of microglioma out of 14 butterfly tumors in the brain in his series.

About 12 cases have been reported in the literature to have extraneural involvement.

Most of the articles on microglioma focus mainly on the pathology; very few articles are written about the management. Radiotherapy doses reported in literature are not uniform. The dose varies from 2000-5000 rads. Segerman noted that doses below 3000 rads did not control tumor while increasing the dose improves the survival.

At the current time 4500-5000 rads to the whole brain is the recommended treatment. Multifocal disease makes whole brain treatment necessary.

Survival in all the big series¹⁰ are almost equal and as follows:

Survival with supportive care, 1.8 to 3.3 months

Survival with surgery alone, 4.6 months

Survival with surgery and radiotherapy, 15-17 months

Littman reported one long time survival after 13 years. Another patient died after 10 years with squamous cell carcinoma of the tongue.

Schauder reported in 1972 a group of 12 patients treated with surgery and radiation therapy. According to him, survival of three to five years is not unusual.

Fellinger reported six of 68 patients alive at various periods of time, from one year to 12 years.

Discussion

Microglioma is an interesting tumor. There is endless controversy regarding the true nature of this disease. Willis described microglioma in his book

Pathology of Tumors as "tumors believed to arise from the perivascular histiocytes or microglial cells of the brain, tumors corresponding to those of reticulo-endothelial tissues of other parts of the body."

Rio Hortega has shown that microglial cells are mesodermal in origin and represent a portion of the reticulo-endothelial system. These cells are scattered irregularly in both gray and white matter and among the astrocytes and oligodendrocytes. A microglial cell may be transformed to a mononuclear macrophage. They are then known as scavenger cells.

The five-year survival rate for extraneural reticulum cell sarcoma has been reported to vary from 20% to 50%. Newall proposed that the prognosis is site specific and the prognosis of brain reticulum cell sarcomas uniformly poor. In an article in *Cancer*, 1975, Littman reported five disease-free survivors of five or more years out of 150 cases reported in the literature. This is only 4% disease free year survival.

The interesting thing about this uncommon tumor is multifocality, butterfly type of tumor, minimal involvement outside the brain, and occurrence in patients with renal transplant. At the present time the only way to treat the patient is by surgery followed by local radiation therapy. ★★★

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References

1. Bailey, P.: Intracranial sarcomatous tumors of leptomeningeal origin. *Arch. Surg.* 18:1359-1399, 1929.
2. Yuile, C. L.: Case of primary reticulum cell sarcoma of the brain. *Arch. Surg.* 18:1036-1044, 1939.
3. Fisher, E. R., Davis, E. R., and Lemmen, J. J.: Reticulum-cell sarcoma of brain (microglioma). *Arch. Neurol.* 81:591-598, 1959.
4. Rubinstein, L. J.: Tumors of the central nervous system. *Atlas of Tumor Pathology*, 2nd series, Washington, D.C., Armed Forces Institute of Pathology, 1972.
5. Polak, M.: Microglioma and/or Reticulosarcoma of the Nervous System. *Acta Neuropath.* (Berlin), Suppl. VI, 115-118, 1975.
6. Henry, J. M., Heffner, R. R., Dillard, S. H., Earle, K. M., and Davis, R. L.: Primary Malignant Lymphomas of the Central Nervous System. *Cancer* 34:1293-1302, 1974.
7. Burstein, S. D., Kernohan, J. W., and Uihlein, A.: Neoplasms of the Reticuloendothelial System of the Brain. *Cancer* 16:289-305, 1963.
8. Henry, J. M., Heffner, R. R., Dillard, S. H., Earle, K. M., and Davis, R. L.: Primary Malignant Lymphomas of the Central Nervous System. *Cancer* 34:1293-1302, 1974.
9. Schneck, S. A., and Penn, I.: De-nevo brain tumors in renal transplant recipients. *Lancet* i:983, 1971.
10. Fisher, D., Mantell, B. S., and Urich, H.: The clinical diagnosis and treatment of microgliomatosis: report of a case. *J. Neurol., Neurosurg., Psychiat.*, 32:474-478, 1969.

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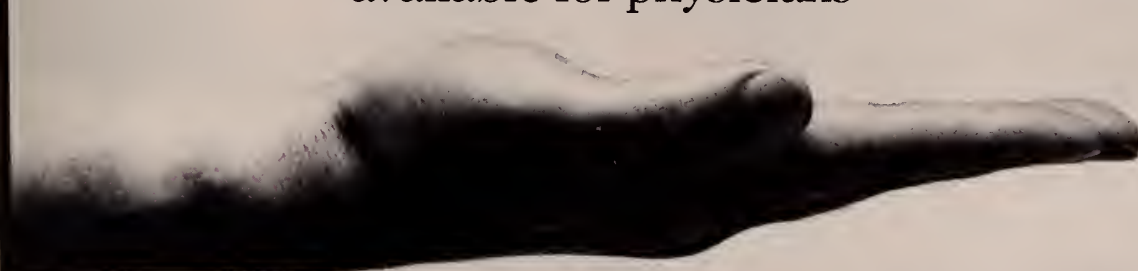
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Radiologic Seminar CCXXI: The T-Tube and Its Tract — Details Which Assist in Percutaneous Retained Stone Removal

KENNETH G. CARTER, M.D.
Jackson, Mississippi

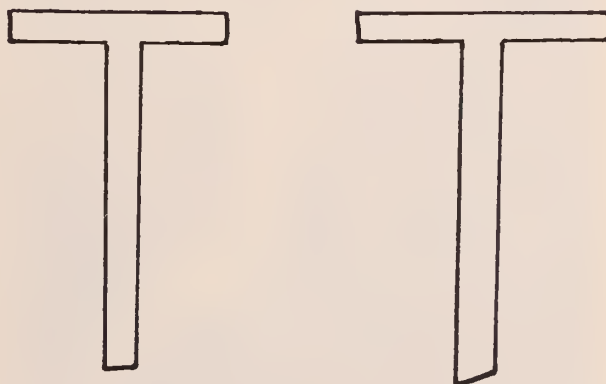
DESPITE COMMON DUCT exploration and operative cholangiography, retained biliary stones occasionally occur. Percutaneous removal of retained biliary ductal stones can be carried out by the radiologist under fluoroscopic control; and when successful, repeat surgery is avoided. Percutaneous removal of biliary ductal stones requires a fibrotic T-tube tract as access to the biliary system. The T-tube should remain in place 5-6 weeks. If bile drainage ceases before this time, immediate cholangiography should be done to establish position of the tube and repositioning should be done if necessary in an attempt to maintain a tract.

Experience over several years has shown that details in the selection and placement of the T-tube are critical in facilitating percutaneous stone removal. Consideration of several factors by the surgeon during surgery can be of tremendous benefit later should retained stone removal become necessary.

Selection of the T-tube and its size: A relatively large T-tube stem is necessary, at least 14 French, as its tract will be utilized to pass catheters and wire baskets into the biliary system, and stones will be removed through this tract. The conventional T-tube has a uniform size of both the cross bar and stem. In patients with small common hepatic-common bile ducts, the Whelan-Moss T-tube is advantageous as the stem is 4-6 French sizes larger than the cross bar.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Mississippi Baptist Medical Center, Jackson, MS.

Figure 1



CONVENTIONAL T-TUBE
Cross Bar 14 French
Stem 14 French

WHELAN-MOSS T-TUBE*
Cross Bar 12 French
Stem 18 French

Thus, even small common hepatic ducts can be provided with satisfactory access through a tract at least 14 French size (see Figure 1). If a Whelan-Moss T-tube is not available for a patient with relatively small ducts, a 14 French conventional T-tube could be used after cutting the cross bar portion of the tube longitudinally to decrease its effective diameter.

* Available in various sizes. Davol, Inc., Cranston, R.I.

RADIOLOGIC SEMINAR / Carter

Course of the T-tube: The course of the stem portion of the tube should be relatively straight but allowing some laxity for respiratory motion. If acute angulation is avoided, catheters, guidewires and wire baskets can be introduced easily.

T-tube exit site from the abdominal wall: A laterally positioned exit site in the right subcostal region is preferable. Anterior exit sites or exit sites near the midline are undesirable since percutaneous stone removal requires fluoroscopic observation, and the manipulation of the tubes and catheters frequently results in radiation exposure to the operator's hands. If leaded gloves are used, they may obscure the field of view. With the hands laterally out of the x-ray beam, this is not a problem.

The angle at which the stem of the T-tube meets the common hepatic-common bile ducts should be as close to perpendicular as possible: Acute angulation or any abrupt bend as the tube enters the duct limits manipulation in the duct system. If the tube is placed such that the stem portion of the tube is approximately perpendicular to both the common hepatic and common bile ducts, either of these ductal structures can be easily catheterized.

Attention to details in the selection and placement of a T-tube by the surgeon can make subsequent removal of unexpected retained ductal stones easier on the patient and more successful for the radiologist (see Figures 2, 3, 4). ★★★

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Figure 2. Favorable T-Tube Placement and Course of the T-Tube Stem: The relationship of the stem of the T-tube to the common hepatic and common bile ducts is almost perpendicular. Exit site of the T-tube is laterally on the right and the course of the stem is relatively straight.



Figure 3. Unfavorable T-Tube Placement: The stem portion of the T-tube exits just to the left of midline at the L1 level. There is an acute angulation between the stem portion of the tube and the portion of the cross bar in the common bile duct.



Figure 4. Same Patient as in Figure 3: Right posterior oblique projection during cholangiography shows that there is an acute bend just before entering the common bile duct posteromedially.

114th Annual Session May 2-6, 1982 Biloxi Hilton

Evaluation of a Pelvic Mass

G. RODNEY MEEKS, M.D., Moderator

DR. MEEKS: A 19-year-old, nulliparous, white woman presents because of pelvic fullness of two months duration which has recently become worse. Mild aching pelvic pain begins immediately upon arising in the morning, radiates into her dorsal left thigh, into her lower back, and into her left hip. The pain is made worse by exercise and is relieved somewhat by rest. She has noted no bowel or bladder symptoms, no weight loss or gain, and no increased abdominal girth. Her menses occur every 28 days and last four days, and her last menstrual period occurred two weeks ago. She experiences mild dysmenorrhea which is not incapacitating and does not seem to be more than her peers. She does not use hormonal contraception.

She is a well developed, well nourished, young white woman who weighs 125 pounds. The abdomen is flat with no organomegaly or masses. Deep palpation in the right lower quadrant produces very mild pain. The patient's external genitalia are normal. Her vagina is pink, rugated, and well estrogenized. The cervix is free of gross lesions, and there is a copious quality of endocervical mucus consistent with mid-cycle. The uterus is anteverted, and nulliparous size. A large irregular cystic mass fills the pelvis and rests behind the uterus. Neither adnexa can be separated from the mass which fills the cul-de-sac. The mass is tender to palpation and 10 cm in greatest dimension. The rectal examination confirms the pelvic examination and no intrinsic rectal lesions are present. What additional history would be important?

DR. BOURGEOIS: A history of pelvic inflamma-

Panelists: William Cook, M.D., of Jackson, Mississippi and Michael Bourgeois, M.D., of Biloxi, Mississippi. Bill Pace, M.D., resident, prepared the case.

tory disease, skeletal problems, or neuromuscular problems could explain the pain. Are there any associated pains or symptoms outside the pelvic region? Is she febrile and is she sexually active?

DR. COOK: The possibility of pregnancy should be determined by asking about sexual history, contraceptive use, and subjective symptom of pregnancy including breast tenderness, urinary frequency, nausea, and tiredness or fatigability. I might add that most women will not volunteer information about the sexual history, but when asked in a tactful manner are quite open. Dyspareunia often is associated with pelvic pathology.

DR. MEEKS: She is sexually active with no dyspareunia. She has no history of pelvic infection or unexplained febrile illnesses and no associated symptoms. When you see a patient with lower abdominal pain, what do you consider in the differential?

DR. BOURGEOIS: Ovarian cyst, ovarian torsion, ectopic pregnancy, tubo-ovarian abscess, appendicitis, nonspecific functional bowel complaints, ureteral colic, ulcerative colitis, and ileitis are all possibilities. In fact, enteritis seems to be almost an epidemic in young women. Even aseptic necrosis of the hip may present as lower quadrant pain. Malignancy, although rare, is always a possibility and germ cell tumors (dysgerminoma, immature teratoma, endodermal sinus tumor, choriocarci-

noma) may be present in this age group.

DR. COOK: She has dysmenorrhea, she is 19 years old, and she has a mass, all of which are consistent with endometriosis or endometrioma. However, endometriosis is not common before age 20 and endometriomas do not commonly rupture.

DR. MEEKS: What further evaluation would you do?

DR. COOK: I would begin by ordering a pregnancy test, pap smear, CBC, urinalysis, and cervix culture.

DR. MEEKS: Her pregnancy test, pap smear, and cervix culture are negative. Her hematocrit is 35%, and white count is 8,000 WBC/mm³ with a normal differential. Her urinalysis is normal. What x-ray studies would you order for an evaluation of a pelvic mass?

DR. BOURGEOIS: I would request an intravenous pyelogram, barium enema, and sonogram. The IVP is important to rule out a pelvic kidney and to locate the ureters which may be obstructed or distorted. The barium enema rules out intrinsic bowel disease and allows one to see if there is significant large bowel involvement with the mass. The sonogram allows one to define the exact size of the cyst and whether there are any solid portions in the cyst.

DR. MEEKS: Dr. Pace, please show the x-rays and sonogram.

DR. PACE: The IVP shows a soft tissue mass but a normal urinary system. The barium enema shows the same soft tissue mass and some distortion of the rectum but no intrinsic bowel lesions. The sonogram shows a multiloculated cystic mass present in the cul-de-sac which is 11 cm in greatest dimension.

DR. MEEKS: With a pelvic mass of this proportion, would you follow this patient or would you proceed to exploratory laparotomy?

DR. BOURGEOIS: Any pelvic mass which is discovered before puberty or after menopause warrants an extensive evaluation which includes exploratory laparotomy. During the reproductive years, asymptomatic masses may be followed if they are cystic and less than 5 cm in diameter. Any mass which persists longer than two cycles, is larger than 5 cm, or feels solid warrants surgery.

DR. MEEKS: What special preparations are necessary in the preoperative period?

DR. BOURGEOIS: Even though we all are very interested in the preservation of reproductive function in a young woman, I think the patient must be prepared psychologically for hysterectomy and for the possibility that she may be required to take hormones for the rest of her life. The patient should be

informed not only of the plans for surgery, but also of the contingencies, for psychological reasons as well as medico-legal reasons. This is reflected in my consent form.

DR. COOK: I would do a mechanical bowel prep, if time allows and ordinarily I do not give antibiotics. A surgical consult would be helpful to evaluate possible bowel involvement and a surgeon should be available if the bowel surgery were necessary.

DR. MEEKS: The discussion to this point has centered on the work-up of a new pelvic mass. Additional history will make the case more interesting. Approximately six months prior she had severe right lower abdominal pain, was diagnosed as having an acute abdomen, and underwent an appendectomy. A right ovarian cyst was noted at the same time. How commonly do you see a patient being explored for one problem, particularly appendicitis, and then finding ovarian pathology?

DR. COOK: It is not uncommon at all, but we must remember how difficult it is to determine the etiology of an acute abdomen. Once a patient undergoes laparotomy, often the appendix is removed whether or not it is actually inflamed. It is not unusual to see a patient who has a corpus luteum cyst with hemorrhage, and who has the ovary, tube, and appendix removed. I feel it is extremely important to get the results of the previous surgery, to speak with the surgeon if possible, and to review the pathology slides and reports before proceeding any further.

DR. MEEKS: The pathology report revealed that the patient had acute appendicitis but also had endometriosis of the appendix. A portion of ovary was submitted and was consistent with endometriosis. The operative note revealed that the woman was lapped because of appendicitis through a McBurney incision. In the process of entering the abdomen and isolating the appendix, the surgeon noticed chocolate brown material coming from the pelvis. He reported a right ovarian cyst, which had been ruptured. He biopsied the cyst and then repaired the ovary. Would you now consider any alternative therapies?

DR. BOURGEOIS: I think this patient has endometriosis and endometrioma. Endometriosis of the bladder, bowel, and appendix is common in severe cases. Danazol reduces the amount of endometriosis and sometimes even large endometriomas regress in size and completely disappear with therapy. I would still do an exploratory laparotomy, however, because I feel the pelvis and mass have not been adequately evaluated.

DR. COOK: If we assume that the mass is endometriosis — should you approach it surgically and

then medically or begin medically and then treat surgically? I tend to treat medically and then treat surgically, because every time the abdomen is entered, a woman's reproductive capacity is compromised by creating adhesions and scarring the fallopian tubes. I would treat her with danazol or one of the progestational compounds. A mass 10 cm in size is still a problem. Although the surgeon described endometriosis and this was confirmed on the pathology report, only the right side was explored and another problem could be coincident with the endometriosis. If this patient had not previously been evaluated, I would perform an exploratory laparotomy.

DR. MEEKS: Endometriosis was the working diagnosis. She did not undergo exploratory laparotomy because it was felt that regression with the danazol would prove this was endometriosis. How long would you wait before you would proceed to surgery?

DR. COOK: Danazol acts in four to six weeks. If the mass did not significantly change in size, I would then proceed to surgery.

DR. MEEKS: How long do you treat the patients?

DR. COOK: With a reduction in size, I would continue danazol for six months, then switch her to a progesterone therapy and continue that until she desires pregnancy. Also, I would encourage pregnancy as soon as practical.

DR. BOURGEOIS: Once I start therapy I continue it for four to six months. I may continue longer depending on the situation. If the symptoms have resolved and the patient desires children, I just stop

the danazol and allow her to conceive. If she desires contraception, I place her on low dose oral contraceptive pills. As an alternative, I would use progestational agents to control the disease.

DR. COOK: Many women have nausea, acne, depression, hirsutism, and loss of libido while taking danazol. Often they stop the drug themselves because of these side effects and only come back to the office because the pain returns. Danazol is expensive and sometimes the patients will not admit that they can not afford the drug.

DR. MEEKS: She was started on danazol and her main complaints are hot flashes, increased amount of acne, and increased oiliness of her skin. Her symptoms improved dramatically and the mass regressed in size. After three months she continues to have a 4 cm mass. The plan is to continue danazol for six to nine months, and then re-evaluate. She will then be placed on oral contraceptives unless she desires pregnancy.

I would like to express my appreciation to Dr. Cook and Dr. Bourgeois for their participation. Your clinical discussions are beneficial and enjoyable. Thank you. ★★

2500 North State Street (39216)

Acknowledgement

The Department is grateful to Dr. Leo E. Gibson, Jr. of Picayune, Dr. John R. Sanders of Tupelo, and Drs. Mercer Lee, III, Earl T. Stubblefield, and Lawrence S. Goldstein of Jackson, for their participation on earlier panels.

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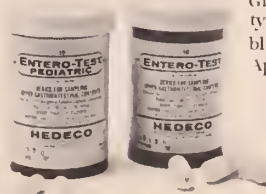
References:

Rosenthal, P. and Liebman, W.M: Comparative study of stool examinations, duodenal aspiration, and pediatric Entero-Test for giardiasis in children. *J. PEDIAT.* 96: 278 (Feb.) 1980.

Thomas, G. E., et al: Use of the Entero-Test duodenal capsule in the diagnosis of giardiasis. *South Afr. Med J.* 48: 2219, 1974.

Lopez, M. E., et al: Infeccion duodeno-yeunal en el niño con desnutricion energetico-proteinica. *Rev. Med. Hosp. Nat. Niños* 13: 53, 1978.

Gilman, R. H: Identification of gall typhoid carriers by a string bladder device. *The Lancet*: April 14, p. 795, 1979.



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The President Speaking

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R. FASER TRIPLETT
Jackson, Mississippi

Some of you attended a Leadership Conference our association conducted in Jackson last month to discuss the many changes we can expect in health care in the 80's. It was a very worthwhile program. I am sorry that more of our members didn't avail themselves of the opportunity to be forewarned and therefore prepared for what may occur in the future.

The late Senator Dirksen once commented to his colleagues about their votes on various new programs that "a million here and a million there soon adds up." The comments of our speakers at the Leadership Conference indicate that the millions here and the millions there for health care have now added up to a total we can no longer afford.

The President and our friends in Congress are all saying that there will have to be further cuts in federal health programs. Senator Robert Dole, chairman of the Senate Finance Committee, recently cited the Medicare Program as a \$56 billion disaster and went on to say that maybe Congress made a mistake in not enacting President Carter's proposal to place an arbitrary cap on hospital costs. President Reagan is expected to announce soon a "Consumer Choice Plan" for health insurance which will encourage our patients to shop around for quality health services at a reasonable cost.

It will behoove all of us to practice more efficiently. There will be further leveling off if not a reduction in monies for Medicare, Medicaid and other government funded health programs. First dollar coverage by public and private third party payors will soon become a thing of the past. I believe we will see our patients more and more asking what something costs and what we can do as a less costly alternative. If it is true as some say that people will consume as much health care as someone else will pay for, then we can expect the opposite of this when the "someone" starts paying less.

★★★

EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XXIII, Number 4

APRIL 1982

Weaning Is Difficult

Dependency is so easily achieved and weaning so difficult to accomplish.

The federal government has succeeded in making nearly every segment of society dependent on its "largess" to some extent. What is perceived at first to be a benevolent gift is soon looked upon as its "just due" and, it follows shortly, an absolute necessity.

Many physicians who refuse to participate in the medicaid program and disapprove so heartily of federal handouts have received their education on interest subsidized loans.

Much of medical education depends on entitlement programs.

Our teaching hospitals would be sorely put to survive if medicaid programs were suddenly stopped, and certainly many of the smaller hospitals throughout the state would be forced to close if this were discontinued.

It appears that dependency has passed the limit of tolerance and all that is attempted at present is a slowing of its escalation, but it certainly raises cries of anguish.

As longevity increases and medicine becomes more sophisticated and costly, at some point we must decide who is worth salvaging and at what cost. Can our system of government with its largely Judeo-Christian ethic face these issues?

W. MONCURE DABNEY, M.D.
Editor

Medico-legal Brief

Hospital Committee Records Not Discoverable in Suit

The proceedings of a medical review committee conducting peer review were not subject to discovery in a medical malpractice action, a federal trial court in Connecticut ruled.

A patient who had filed a malpractice action against a physician served a subpoena on the administrator of a hospital where the physician had staff privileges. The subpoena requested production of the

proceedings of a peer review committee. The trial court ruled that Connecticut law governed the case and that a statute barred discovery of peer review proceedings unrelated to the subject matter of the suit.

The court said that the purpose of the statute was to encourage physicians to evaluate their peers without fear of disclosure and that that purpose would be hampered by public release of any proceedings, not just those involving the patient who sued. The overriding importance of the review committees to the medical profession and the public required them to be conducted in an atmosphere of complete confidentiality, the court said. — *Morse v. Gerity*, 520 F.Supp. 470 (D.C., Conn., June 4, 1981)

RECOLLECTIONS

Twenty years ago, the April 1962 issue of JOURNAL MSMA announced plans for the association's 94th Annual Session, to be held in Jackson at the Hotel Heidelberg. Dr. Lawrence W. Long of Jackson was MSMA president, Dr. C. P. Crenshaw of Collins was president-elect, and Dr. C. G. Sutherland of Jackson was secretary-treasurer and chairman of the Council on Scientific Assembly.

As part of a Symposium on Space Medicine, several special exhibits were to be displayed, including an operational duplicate of the Mercury spacecraft and escape tower. Working with MSMA in planning the symposium were the U. S. Aerospace Medical Center, the U. S. Air Force School of Aviation Medicine, the National Aeronautics and Space Agency, and the Office of the Surgeon General of the U. S. Air Force. Among special guest speakers was Senator John C. Stennis, member of the Senate Committee on Aeronautical and Space Sciences.

Seven scientific sections had scheduled educational programs during the session.

The MSMA Auxiliary announced plans for its 39th Annual Session, to be held at the Hotel King Edward. Mrs. John G. Egger of Drew was serving as president, and Mrs. A. T. Tatum of Petal was president-elect.

POSTGRADUATE CALENDAR

April 24, 1982

UROLOGY VISITING PROFESSOR PROGRAM
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Surgery Division of Urology and the Medical Center Division of Continuing Health Professional Education.

Coordinator: W. Lamar Weems, M.D., professor of surgery (urology) and chief of the division of urology, University of Mississippi School of Medicine.

This seminar is designed to cover the latest developments in genitourinary trauma and bladder dysfunction. Guest speaker is Dr. Fletcher C. Derrick, clinical professor of urology at the Medical University of South Carolina. The program is made possible in part by the Urology Continuing Medical Education Fund of the University of Mississippi Alumni Association. There

is no registration fee. Credit 5 contact hours (.5 CEU), Category I of the AMA Physician's Recognition Award.

May 22-23, 1982

NUCLEAR MEDICINE UPDATE
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Radiology Division of Nuclear Medicine, the Medical Center Division of Continuing Health Professional Education and the Mississippi Society of Nuclear Medicine.

Coordinator: Jane Sanders, M.D., associate professor of radiology, University of Mississippi School of Medicine.

This program will focus on developments in clinical nuclear medicine imaging. Major emphasis is on newer techniques as well as established procedures. Fee: \$65 for Mississippi Society for Nuclear Medicine physician members; \$75 for nonmembers. Credit: 8 contact hours (.8 CEU), Category I of the AMA Physician's Recognition Award.

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INDICATIONS AND USAGE SU-TON contains pentylentetrazol which may be helpful in the older patient as an analeptic agent when mental confusion and memory defects are present. SU-TON also contains vitamins, trace minerals, and iron, for those patients who may benefit by preventing the development of a deficiency.

CONTRAINDICATIONS Epilepsy, convulsive disorders or known history of sensitivity to any of the listed active ingredients.

WARNINGS The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS Although there are no absolute contraindications to pentylentetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of SU-TON who have heart disease. While pentylentetrazol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

ADVERSE REACTIONS Pentylentetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylentetrazol.

DRUG ABUSE Drug dependence has not been reported with SU-TON.

OVERDOSAGE Signs and symptoms of acute overdose may be due principally from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures. If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage. Intensive care must be provided to maintain adequate circulation and respiratory exchange.

DOSAGE AND ADMINISTRATION One tablespoonful (15 ml) 3 times a day 20-30 minutes before meals. This drug is not for use in children under 12 years of age.

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NEW MEMBERS

BOLAND, MICHAEL J., Jackson. Born Lexington, KY, June 28, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned Fitzsimmons Army Medical Center, Denver, CO, one year; medicine residency, same, 1973-75; cardiology fellowship, same, 1975-77; elected by Central Medical Society.

BROCKMANN, JOHN L., Grenada. Born High Point, NC, Dec. 23, 1929; M.D., Duke University School of Medicine, Durham, NC, 1953; interned Hartford Hospital, Hartford, CT, 1953-55; surgery residency, Emory University Hospital, Atlanta, 1955-57; thoracic surgery residency, Grady Memorial Hospital, Atlanta, and V.A. Hospital, Atlanta, 1957-62; elected by North Central Medical Society.

BROWN, THAIS EMILY, Jackson. Born Laurel, MS, Nov. 6, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and family practice residency, University Medical Center, Jackson, 1978-81; elected by Central Medical Society.

CARTER, RALPH R., III, Jackson. Born Columbus, MS, Feb. 26, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned, medicine residency, and pulmonary fellowship, University Medical Center, Jackson, 1976-81; elected by Central Medical Society.

HORTON, THOMAS L., Purvis. Born Natchez, MS, Nov. 4, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned University of Alabama/Jackson Hospital and Clinic, Montgomery, AL, one year; elected by South Mississippi Medical Society.

JEFFCOAT, GERRY L., Columbus. Born Choctaw County, June 6, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned, surgery residency and thoracic surgery, University Medical Center, Jackson, 1972-79; elected by Prairie Medical Society.

LYON, GEORGE DAVIS, Jackson. Born Greenwood, MS, July 18, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and anesthesiology residency, University Medical Center, Jackson, 1978-81; elected by Central Medical Society.

MCATLEY, DOUGLAS L., Natchez. Born Edmonton, Alberta, Canada, Feb. 11, 1944; M.D., University of Alberta Faculty of Medicine, Edmonton, 1968; interned and anesthesiology residency, Royal Alexandra Hospital, Edmonton, 1968-73; anesthesiology residency, Vancouver General Hospital, Vancouver, Canada, 1973-75; elected by Homochitto Valley Medical Society.

MCBRAYER, JOHN DAVID, Columbus. Born Columbus, MS, May 29, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and medicine residency, University of Alabama Medical Center, Birmingham, 1978-81; elected by Prairie Medical Society.

MCCAA, CONNIE SMITH, Jackson. Born Lexington, MS, Dec. 6, 1937; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned and ophthalmology residency, University Medical Center, Jackson, 1977-81; elected by Central Medical Society.

NAGAPPA, CHAMPA, Starkville. Born India, March 15, 1948; M.D., India, 1971; interned and pediatric residency, University South Florida, Tampa, 1978-81; elected by Prairie Medical Society.

ROBERTS, E. LEONARD, Jackson. Born Selma, AL, March 25, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and family medicine residency, University Medical Center, Jackson, 1978-79; family medicine residency, University of Virginia, Charlottesville, 1979-81; elected by Central Medical Society.

ROBY, MILTON L., Natchez. Born Durant, MS, Nov. 22, 1934; M.D., University of Mississippi School of Medicine, Jackson, 1965; interned Georgia Baptist Hospital, Atlanta, 1965-66; elected by Homochitto Valley Medical Society.

STRIPLING, JOHN ROBERT III, Gulfport. Born Miami, FL, April 21, 1948; M.D., University of Miami School of Medicine, 1974; interned and urology residency, Baptist Memorial Hospital, Memphis, TN, 1974-76; urology residency, Charity Hospital, New Orleans, and Long Hospital, Baton Rouge, 7/76-6/79; elected by Coast Counties Medical Society.

WALROD, JOHN GODFREY, Hattiesburg. Born Ft. Smith, AR, July 6, 1943; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned Spartanburg General Hospital, Spartanburg, SC, 1973-74; elected by South Mississippi Medical Society.

NEW MEMBERS / Continued

WELDON, THOMAS EDWARD, Grenada. Born Jersey City, NJ, Dec. 17, 1946; M.D., College of Medicine and Dentistry of New Jersey-New Jersey Medical School, Newark, 1972; interned, general surgery residency, and urology residency, Case Western Reserve, Cleveland, OH, 1972-77; elected by North Central Medical Society.

PERSONALS

JAMES ACHORD of UMC recently attended an executive committee meeting of the American College of Gastroenterology in Philadelphia, Pennsylvania.

J. PATRICK BARRETT of Jackson has been inducted as a fellow of the American Academy of Orthopaedic Surgeons.

WILLIAM BATES of UMC was a visiting professor at Keesler Air Force Base in Biloxi.

WILLIAM L. CARR, JR. announces the opening of his office for the practice of general medicine at 608 Second Avenue in Laurel.

A. WALLACE CONERLY of UMC recently spoke to members of the Montfort Jones Memorial Hospital Staff in Kosciusko.

CARL EVERS of UMC presided at the executive committee meeting of the Southern Group on Student Affairs of the Association of American Medical Colleges on St. Simons Island.

JAMES HARDY of UMC attended an editorial board meeting of the *World Journal of Surgery* in Basle, Switzerland, in February.

JAMES E. HARRIS of Hattiesburg announces the relocation of his practice of ear, nose and throat medicine to 710 South 28th Avenue.

JAMES C. HAYS of Jackson has been named chief of staff at St. Dominic-Jackson Memorial Hospital. Other officers are WILLIAM C. MAYFIELD, chief-elect; W. H. MERRELL, JR., past chief; and SIDNEY R. BERRY, secretary-treasurer.

FRED HECKLER of UMC recently lectured at the Allegheny General Hospital in Pittsburgh, Pennsylvania.

JAMES M. HOLSTON of Laurel has been elected to fellowship in the American Academy of Pediatrics.

EDWARD T. JAMES, JR. of Jackson has been inducted into fellowship in the American Academy of Orthopaedic Surgeons.

DEWEY H. LANE, JR. of Pascagoula has been inducted into fellowship of the American College of Chest Physicians.

GEORGE A. MARSH, JR. of Meridian has been certified as a diplomate of the American Board of Pediatrics.

A. N. NICHOLS of Centreville has been appointed chief of staff at the Field Memorial Community Hospital for 1982.

JOE NORMAN of UMC recently was a site visitor for the National Institutes of Health to the Charles R. Drew Medical School in Los Angeles.

WAYNE M. PITRE of Vicksburg has become a diplomate of the American Board of Dermatology.

JAMES Q. SONES, II of Jackson has been elected to fellowship in the American College of Physicians.

TATE THIGPEN and RALPH VANCE of UMC participated in a panel of medical experts for the second annual Youth Press Conference sponsored by the American Cancer Society at Millsaps College in Jackson.

FRAZIER WARD of UMC recently taught a continuing education course for orthopedic surgeons in Toronto, Ontario, Canada.

ROY WILSON of UMC was consultant for a medical practice management seminar in Acapulco, Mexico.

WINFRED WISER of UMC was guest lecturer at the Louisiana State University School of Medicine in Shreveport.

JAMES P. WOOD of Waynesboro announces his association with ARTHUR E. WOOD, III, in the general practice of medicine.

GUY T. VISE, JR. of Meridian has been elected to two positions in the Southern Medical Association — vice chairman of the Council and vice chairman of the Section on Orthopedic Surgery.

JOURNAL MSMA encourages your participation. Comments, inquiries and suggestions are invited.

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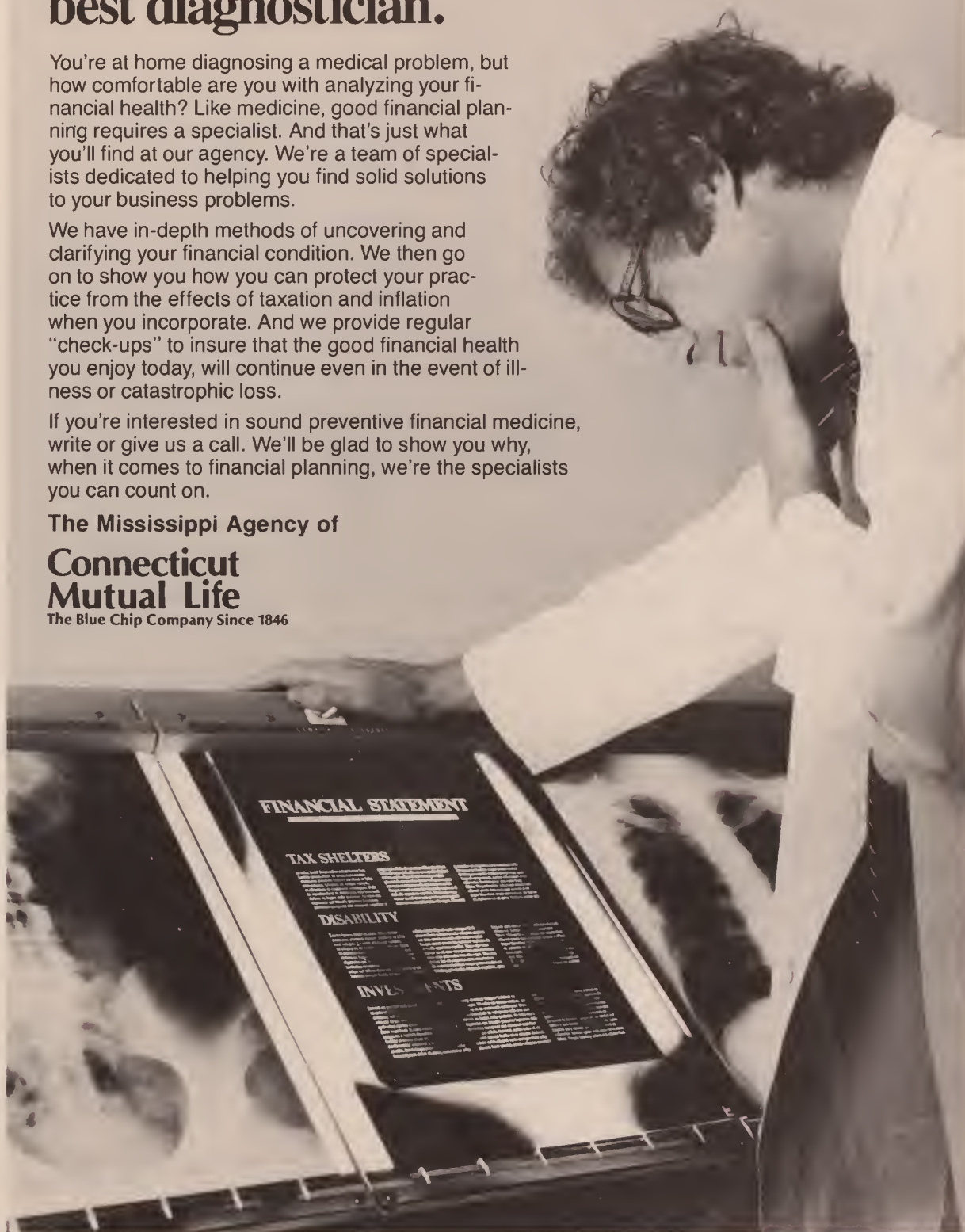
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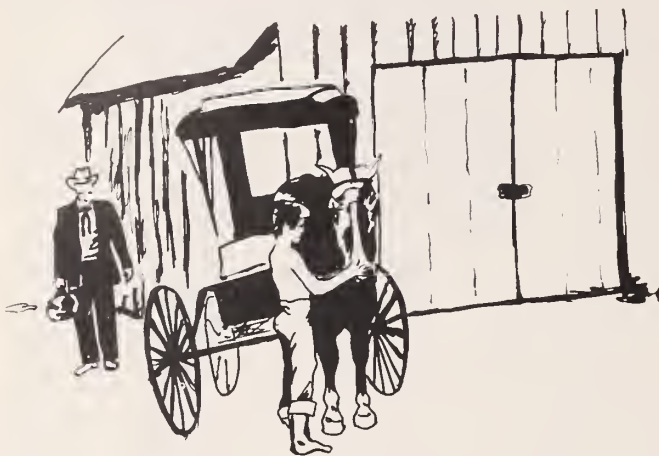
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When the Mississippi State Medical Association was founded on December 15, 1856, medicine was truly in the "horse and buggy" days. Remarkable progress has been made in the past 125 years.

To illustrate that progress, a special historical exhibit will be on display during the association's 114th Annual Session, May 2-6, 1982, at the Biloxi Hilton. Many of the items will be on display later at the "Country Doctor's Office" which the MSMA is constructing at the Mississippi Agricultural and Forestry Museum in Jackson.

MSMA IS SEEKING MEDICAL ARTIFACTS

If you can obtain any medical artifacts (instruments, equipment, documents, etc.) for display in the special annual session exhibit, please bring them with you and share them with your colleagues and guests.

114th Annual Session

Mississippi State Medical Association

May 2-6, 1982

Biloxi

The upcoming 114th Annual Session of the Mississippi State Medical Association has a particular significance. In addition to carrying out the association's primary business and continuing medical education functions, the meeting will mark the 125th Anniversary Year of the MSMA.

Few organizations can claim to have been in existence for 125 years, and a number of special activities have been included in the annual session program to celebrate the milestone.

As in past years, the schedule of events for the five-day meeting includes programs by 14 scientific sections, meetings of more than 20 specialty societies and related groups, a display of scientific exhibits, several medical alumni occasions, a host of MSMA fellowship and sports activities, and two sessions of the House of Delegates.

Principal speaker at the opening session of the House of Delegates on Monday, May 3, will be Dr. Daniel T. Cloud of Phoenix, Arizona, president of the American Medical Association. Delegates will also hear an address by Dr. R. Faser Triplett of Jackson, MSMA president.

Delegates will receive their complete House of Delegates folders prior to May 2, according to Dr. Carl G. Evers of Jackson, speaker of the House. Dr. Evers will preside over House sessions, along with Dr. James C. Waites of Laurel, vice speaker. The agenda includes action on reports and resolutions, election of officers, presentation of awards, and the installation of Dr. Sidney O. Graves of Natchez as 1982-83 president.

Continuing medical education credit will be awarded for the scientific assembly, which begins on Sunday, May 2 and continues through Wednesday afternoon, May 5.

Among the many medical related groups which have scheduled meetings in conjunction with the annual session are the Mississippi Medical Fraternal and Educational Society (Sunday afternoon at 3:30)

OFFICIAL CALL

To all members of the Mississippi State Medical Association:

The 114th Annual Session of the Mississippi State Medical Association is called to meet at Biloxi, Mississippi, on Sunday, May 2, 1982, pursuant to Article V of the Constitution. The House of Delegates will be convened at the Biloxi Hilton at 9:00 a.m. on May 3.

The Scientific Assembly, consisting of the 14 Scientific Sections, will meet during May 2-5, 1982.

No member or guest will be permitted to participate in any aspect of the annual session until regularly registered.

R. FASER TRIPLETT
President

J. Elmer Nix
Secretary-Treasurer

and the Mississippi Foundation for Medical Care (Monday afternoon at 1:30).

Two MSMA banquets, one featuring Abigail Van Buren (Dear Abby) as guest speaker and the other honoring the MSMA past presidents in a celebration of the 125th anniversary, have been set for Tuesday and Wednesday evenings. Medical alumni organizations will host receptions on Monday evening.

The annual tennis and golf tournaments, the fishing rodeo, and a special historical display of medical artifacts are just a few of the special activities rounding out the schedule for the 114th Annual Session.

Room reservations at the Biloxi Hilton should be made directly with the hotel.

SCIENTIFIC PROGRAM

114th Annual Session
May 2-6, 1982

SUNDAY, MAY 2

- 8:00 a.m. **MSMA Section on Orthopedics**
The Shoulder and The Knee (Thomas D. Sisk, M.D., Memphis, TN)
- 8:30 a.m. **MSMA Section on Anesthesiology**
Anesthesiology Update: New Cardiovascular Drugs (John R. Cooper, M.D., Texas Heart Institute, Houston, TX)
Report on Progress with Medicare and Medicaid (Herman Crowder, M.D., Jackson, MS)
CPR Education in Mississippi (Thomas Herrin, M.D., Jackson, MS)
Anesthesia Needs in Mississippi for Next Decade (Patricia F. Norman, M.D., Jackson, MS)
Cardiovascular Anesthesia (Dr. Cooper)
- 9:00 a.m. **MSMA Section on EENT**
External Rhinoplasty and Local Anesthesia of the Head and Neck (John McIver Hodges, M.D., Memphis, TN)
Ophthalmology topic and speaker to be announced
- 9:00 a.m. **MSMA Section on Dermatology**
Dermatological Diseases Produced by Drugs (W. Mitchell Sams, Jr., M.D., University of Alabama in Birmingham)
- 9:00 a.m. **MSMA Section on Pathology**
Immunoperoxidase Technique: Application in Surgical Pathology (Warren W. Johnson, M.D. and Jack R. Lewin, M.D., B.C.H., Jackson, MS)
The Shroud of Turin: A Pathologist's Viewpoint (Robert Bucklin, M.D., Los Angeles, CA)
- 9:00 a.m. **MSMA Section on Psychiatry**
Psychosomatic Aspects of Chronic Pain (William Logan Webb, Jr., M.D., University of Tennessee College of Medicine, Memphis, TN)
- 9:00 a.m. **MSMA Section on Radiology**
What CT Can Tell About the Mediastinum (D. J. Aronberg, M.D., Mallinckrodt Institute, St. Louis, MO)
Skeletal Nuclear Medicine (Bharti Patel, M.D., Jackson, MS)
Guided Needle Biopsy of Chest and Abdomen Lesions (Dr. Aronberg)

TUESDAY, MAY 4

- 9:00 a.m. **MSMA Section on Medicine**
Hepatitis Update (presented by the Miss. Gastroenterologic Association)
- 9:00 a.m. **American College of Surgeons, Mississippi Chapter**
Approaches to Resuscitation and Abdominal Trauma in Childhood (James A. O'Neal, Jr.,

M.D., Children's Hospital, Philadelphia, PA)

Management of Thoracic Trauma in Childhood and Management of Splenic Injuries (J. Alex Haller, M.D., Baltimore, MD)

- 1:30 p.m. **MSMA Section on Surgery**
Differential Diagnosis of Abdominal Pain in Infants and Children (Dr. Haller)
Pancreatic Biliary Disorders in Childhood (Dr. O'Neal)
Facial Injuries: Evaluation and Management (James Hendrix, M.D., Memphis, TN)
- 1:30 p.m. **MSMA Section on Preventive Medicine**
Venereal Disease Update: Today's Problems, Chlamydia and Herpes (Paul J. Wiesner, M.D., Center for Disease Control, Atlanta, GA)
Early Detection and Conservative Treatment of Scoliosis (J. Patrick Barrett, M.D., Jackson, MS)

WEDNESDAY, MAY 5

- 9:00 a.m. **MSMA Section on Family Practice**
Hypertension Update: 1982 (Ronald Okun, M.D., Los Angeles, CA)
Pediatric Nutrition: Current Concepts (George Thomas Laven, M.D., Birmingham, AL)
Current Computer Applications in the Family Physician's Office (Bruce McKinnon, Hattiesburg, MS)
Treatment of Emotional Disorders by the Family Physician (Gene Usdin, M.D., New Orleans, LA)
The Stresses of Being a Physician (Dr. Usdin)
- 9:00 a.m. **MSMA Section on Medicine**
Angina Pectoris: A Review (Kenneth Bennett, M.D., Jackson, MS, moderator)
- 1:30 p.m. **MSMA Section on Ob-Gyn**
The Use and Abuse of Antimicrobials in Genitourinary Tract Infections (George A. Pankney, M.D., Oschner Clinic, New Orleans, LA)
Prophylactic Antibiotics for Hysterectomy — Yes or No? (Charles A. Sampson, M.D., Jackson, MS)
Viral Infections in Pregnancy (Rodney Meeks, M.D., Jackson, MS)
Antibiotics — (Panel Discussion)
- 1:30 p.m. **MSMA Section on Urology**
Female Urology As Related to Incontinence and Fistulas (Sheridan W. Shirley, M.D., Birmingham, AL)
- 2:00 p.m. **MSMA Section on Pediatrics**
Anemia of Prematurity (James Stockman, M.D., Syracuse, NY)
Respiratory Management of Hyaline Membrane Disease (Philip G. Rhodes, M.D., Jackson, MS)

MEDICAL ORGANIZATION

AMA President Will Address MSMA House of Delegates



Dr. Daniel T. Cloud of Phoenix, Arizona, president of the American Medical Association, will address the opening session of the House of Delegates on Monday, May 3.

Tennis, Golf, Fishing Events On Annual Session Calendar

Registration is underway for MSMA's annual tennis tournament, golf tournament, and deep sea fishing rodeo. All three events are on the schedule of activities for the 114th Annual Session in Biloxi.

Early registration indicates that trophy winners during last year's events may face strong challenges this year.

The tennis tournament will be directed by Dr. James O. Manning of Jackson and sponsored by the Mississippi Medical Fraternal and Educational Society. The tournament is set for Tuesday, May 4, beginning at 2:00 p.m. at the Biloxi Hilton Courts. Trophies will be awarded to winners and runners-up in men's and women's doubles competition.

Dr. Joe Rogers of Gulfport is chairman of the golf tournament, scheduled to begin at 1:00 p.m. on Tuesday, May 4 at the Broadwater Sea Course. Each participant will be responsible for greens fees and

cart rental. Complimentary tees, towels and balls will be provided. South Central Bell will sponsor the awards reception, where winners will receive trophies for longest drive, closest to hole, first and second place low gross, and first and second place low net.

Two of the Gulf Coast's finest charter boats have been reserved for the deep sea fishing rodeo, according to Dr. Dave Steckler of Natchez, chairman. More than 200 pounds of red fish and mackerel were caught during last year's event. The rodeo is set for Tuesday and Wednesday, May 4 and 5. Boats will leave from the Broadwater Marina at 7:00 a.m. and return at 3:30 p.m. The \$60.00 registration fee covers boat rental for the day, soft drinks and sandwiches.

"Happy 125th Anniversary" Is Fellowship Party Theme

Many surprises are in store for MSMA members, spouses and guests who attend the annual fellowship party, Wednesday, May 5, at the Biloxi Hilton.

Theme of the party is "Happy 125th Anniversary, MSMA." The occasion will celebrate the anniversary year and honor past presidents of the association.

The historical theme will be emphasized in the room decorations, entertainment, and party mementos. Members and spouses are encouraged to dress in clothing suggestive of the era of MSMA's early days.

In addition to the party, other events during the 114th Annual Session will give expression to the anniversary theme.

The Hospitality Center adjacent to MSMA's registration area will feature an anniversary cake for members and guests to enjoy.

A limited edition, commemorative plate will be offered for sale. Proceeds from the sale of the plate will finance the "Country Doctor's Office" which MSMA is constructing as a tribute to the pioneer Mississippi doctors at the state's new Agricultural and Forestry Museum.

The third volume of the *History of the Mississippi State Medical Association* will be presented. Also during the week, there will be a special exhibit of medical artifacts on display.

MMFES Announces Annual Meeting Speaker

James W. Walker, M.D., of Jacksonville, Florida, will offer his perspective on the medical malpractice scene when he addresses the annual meeting of the Mississippi Medical Fraternal and Educational Society (MMFES) on Sunday, May 2. The meeting is scheduled to begin at 3:30 p.m. at the Biloxi Hilton.

Dr. Walker serves the Florida Medical Association as president of the Professional Insurance Management Company (PIMCO).

A native of Cookeville, Tennessee, Dr. Walker attended Vanderbilt University, where he received his B.A. degree in 1949. In 1953 he was graduated from the University of Tennessee with the M.D. degree. He completed a rotating internship and pediatric residency at Duval Medical Center in Jacksonville and a pediatric residency at Charity Hospital, Tulane University, New Orleans.

Dr. Walker left his practice at Children's Medical Group, P.A. in Jacksonville to assume the PIMCO presidency in 1976, but has been retained as consultant to the group. He is a diplomate of the American Board of Pediatrics and a fellow of the American Academy of Pediatrics. He is a 1980 recipient of the AMA Physician Recognition Award.

He served the FMA as secretary-treasurer for five years. He is a past president of the Duval County Medical Society, where he also served as chairman of the Judicial Committee. He has served on the AMA's Committee on Nursing since 1968 and was chairman for two years. He has also served on the National Joint Practice Commission, the Florida Division of Vocational and Technical Education, the Foundation for Medical Care in Duval County, the Northeast Florida Health Planning Council, Duval County Physicians for Better Government, and the Jacksonville Chamber of Commerce. He has been a Rotarian since 1963 and has served as president of his club.

He was instrumental in the development of the Jacksonville University School of Nursing and the School of Nursing at Florida Junior College. He has



served as editorial consultant for *R.N. Magazine*, was on the board of directors of Blue Shield of Florida for six years, and has served as medical advisor to E. R. Squibb & Sons and the A. H. Robins Company.

Practice Management Seminar On Annual Session Program

"Building and Maintaining a Healthy Practice" is the topic of a special seminar for physicians at 1:30 p.m., Saturday, May 1, at the Biloxi Hilton.

The three-hour workshop will be conducted by representatives of the Department of Practice Management of the American Medical Association.

Designed primarily for physicians in small group or solo practice, the seminar will present proven techniques on practice management and will offer special suggestions to keep a medical practice healthy and growing in the 1980s.

Registration is limited for maximum audience participation. The registration fee of \$40.00 includes seminar materials and notebook. For information, contact the MSMA headquarters office.

Luncheon Will Honor 50-Year Club Members

Members of an exclusive club meet each year during the MSMA annual session. Membership in that club is limited to those physicians who have practiced for at least 50 years. When that milestone is reached, those physicians receive a certificate and a lapel pin signifying their accomplishment.

This year the 16 members of the MSMA Fifty Year Club will be honored at a luncheon on Wednesday, May 5, at the Biloxi Hilton. Dr. Whitman B. Johnson of Clarksdale, chairman of the MSMA Board of Trustees, will host the luncheon.

Current members of the Fifty Year Club are: S. Lamar Bailey, M.D. of Kosciusko; T. J. Barkley, M.D. of Belzoni; Sam B. Caruthers, M.D. of Grenada; Charles E. Catchings, Jr., M.D. of Woodville; Thomas F. Clay, M.D. of Tutwiler; Robert B. Harper, M.D. of Fayette; Julius L. Levy, Sr., M.D. of Clarksdale; A. H. Little, M.D. of Oxford; Lawrence W. Long, M.D. of Jackson; Veronica M. Pennington, M.D. of Jackson; G. T. Sheffield, M.D. of Gulfport; Omar Simmons, M.D. of Newton; William C. Simmons, M.D. of Bay Springs; Earl T. White, M.D. of Greenville; H. A. Whittington, M.D. of Natchez; and A. R. Perry, M.D. of Natchez.

Dear Abby Is MSMA Banquet Speaker

One of the most widely read columnists in the world, Abigail Van Buren, will be in Biloxi as guest speaker at the annual MSMA/MSMA Auxiliary banquet, Tuesday, May 4.

"Dear Abby," as she is known to the 65 million readers of her daily column, is also the author of three best selling books and is in wide demand as a lecturer.

She began writing her column in 1956, and although not trained in journalism, became syndicated in less than two months. She is read in Canada, Mexico, Europe, Asia, South America and Africa, and the column has reportedly been "pirated" by some countries behind the Iron Curtain. Through her column, she champions the cause of better mental health.

Abby and her husband of 43 years, Morton Phillips, live in Beverly Hills. They have two children and are also grandparents.



A limited edition, commemorative plate will be available for purchase during the MSMA's 114th Annual Session. The plate was rendered for MSMA to recognize the association's 125th anniversary year and to finance construction of a "Country Doctor's Office" at the Mississippi Agricultural and Forestry Museum in Jackson.

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Annual Session Schedule Includes Alumni Activities

Medical alumni associations from Tulane, the University of Tennessee, and the University of Mississippi have scheduled activities during MSMA's 114th Annual Session.

The University of Tennessee Alumni Association will host a reception for UT medical alumni on Monday, May 3, beginning at 5:30 p.m. at the Biloxi Hilton.

Tulane medical alumni will be entertained Monday evening with a reception beginning at 6:00 p.m. at the home of Dr. Robert A. Little of Gulfport, secretary-treasurer of the alumni group. Dr. Thomas Benefield of Gulfport is president-elect of the Tulane Medical Alumni Association.

Class reunion dinners on Sunday evening at the Biloxi Hilton will kick off Ole Miss alumni activities. Reunions are planned for the classes of 1947, 1952, 1957, 1962, 1967, 1972 and 1977. Class agents and committee chairmen who are planning the reunion dinners are: Drs. S. J. McDuffie of Nettleton; Jack B. McConnell of Basking Ridge, New Jersey; James C. Griffin, Jr., of Jackson; Bobby F. King of Iuka; Walter H. Rose of Indianola; Robert W. Yelverton of Tampa, Florida; Don Mitchell of Jackson; Leonard Ball of Gulfport; and George E. McGee of Louisville, Kentucky.

The annual Seafood Jamboree of the University of Mississippi Alumni Association will be held Monday evening at 7:00, at the Versailles Room of the Royal D'Iberville Hotel.

The University of Mississippi Medical Alumni Past Presidents' Council will meet for breakfast on Monday morning, and the annual business meeting of the Medical Alumni Chapter will be conducted at a breakfast meeting on Tuesday morning. Dr. Joseph H. Johnson of Mount Olive is president of the group. Both meetings will be held at the Hilton.

Sponsors of the Ole Miss activities include: Berlex Laboratories of Cedar Knolls, New Jersey; Bristol Laboratories of Syracuse, New York; Foster Medical Corp. of Jackson, Mississippi; McNeil Pharmaceuticals of Spring House, Pennsylvania, and Roerig Pharmaceuticals of New York, New York.

MSMA Auxiliary Plans 59th Annual Session

The Mississippi State Medical Association Auxiliary will conduct its 59th Annual Session May 2-6, 1982, at the Biloxi Hilton. Registration will open at 9:00 a.m. on Sunday, May 2.

According to convention chairman Mrs. Ed Hill of Hollandale, the General Session will get underway Tuesday, May 4. Special guests at the meeting will be Mrs. Phillip L. Smith, first vice president of the AMA Auxiliary, and Mrs. Keith D. Jones, president of the Southern Medical Auxiliary.

Following the business session, there will be a luncheon and fashion show. Special luncheon guest will be Dr. R. Faser Triplett of Jackson, president of the Mississippi State Medical Association.

Wednesday's schedule includes a breakfast honoring the past presidents of the auxiliary and a makeup/skin care program, "Naturally You," presented by Jennie Shafer.

Convention guests will be invited to purchase hand-made articles and crafts at the auxiliary's Boutique Booth, which will again be located in the Biloxi Hilton Main Lobby. Proceeds will go to the AMA-ERF, and credit will be issued for each local auxiliary toward the AMA-ERF Award.

Auxiliary members will again make arrangements for the Hospitality Center adjacent to MSMA Registration. Members of MSMA and MSMA Auxiliary and convention guests are invited to have bakery treats and coffee or soft drinks at the Hospitality Center. This year there will also be a special 125th Anniversary cake to enjoy.

Working with Mrs. Hill in making convention arrangements are: Mrs. Stanley Hartness of Kosciusko, Mrs. Robert E. Lee of Greenville, Mrs. B. G. Dowdy of Greenville, Mrs. Enrique Flechas of Natchez, and Mrs. Ben Martin of Columbus.

Auxiliary officers are Mrs. John M. Estess of Hollandale, president; Mrs. James Martin of Ocean Springs, president-elect; Mrs. Stanley Hartness of Kosciusko, first vice president; Mrs. James Cooper of Belden, second vice president; Mrs. Ben Martin of Columbus, third vice president; Mrs. Louis Rubenstein of Ocean Springs, fourth vice president; Mrs. Ed Egger of Greenville, recording secretary; Mrs. Sidney Prosser of Hollandale, corresponding secretary; Mrs. Joe Herrington of Natchez, treasurer; and Mrs. A. T. Tatum of Hattiesburg, parliamentarian.



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Each Tablet Contains:

Pentylene-tetrazol.....	25.0 mg
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Clinically proven actions

- Antihistaminic
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Few side effects

- Vasodilation occasionally causes facial flushing which can be minimized by recommending that Ru-Vert® be taken following meals or with food.

Dosage

- One or two tablets three times a day

Please see next page for a summary of prescribing information

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In Vertigo On Balance... **RU-VERT®**

See following prescribing information.

DESCRIPTION: Each tablet contains the following active ingredients:

Pentylentetrazol.	25.0 mg
Pheniramine maleate.	12.5 mg
Nicotinic acid.	50.0 mg

INDICATIONS: Ru-Vert is indicated as an adjunct therapy in the symptomatic treatment of acute or chronic vertigo.

CONTRAINDICATIONS: Convulsive disorders or known history of sensitivity to any of the listed active ingredients. Because of the vasodilating action of nicotinic acid, Ru-Vert should not be used in patients with hypotension.

WARNINGS: The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS: Although there are no absolute contraindications to pentylentetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of Ru-Vert who have heart disease. While pentylentetrazol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

Pheniramine maleate, like other antihistamines, may produce sedative side effects in certain patients.

Transient vasodilatation due to rapid absorption of nicotinic acid may produce facial flushing and a sensation of warmth. These effects may be ameliorated by recommending that Ru-Vert be taken following meals or with food.

ADVERSE REACTIONS: Pentylentetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylentetrazol.

DRUG ABUSE: Drug dependence has not been reported with Ru-Vert.

OVERDOSAGE: Signs and symptoms of acute overdose may be due primarily from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures. If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage.

Intensive care must be provided to maintain adequate circulation and respiratory exchange.

DOSEAGE AND ADMINISTRATION: The recommended dosage of Ru-Vert for vertigo or motion sickness is 1 or 2 tablets three times a day with meals or light snacks.

This drug is not for use in children under 12 years of age.

HOW SUPPLIED:

Bottles of 100 tablets

Bottles of 300 tablets

Federal law prohibits dispensing without prescription.

NDC 0524-0060-01

NDC 0524-0060-03

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UMC Schedules 1982 Commencement

University of Mississippi Medical Center's 1982 Commencement is set for Sunday, May 30, at 4 p.m. in the Jackson City Auditorium.

Some 347 UMC students, including 146 School of Medicine students, expect to receive degrees during the afternoon ceremonies.

Former Lt. Governor Evelyn Gandy will present the graduation address. Ms. Gandy is deputy for human resources for the Mississippi Department of Mental Health.

A reception for graduates in the UMC Schools of Medicine, Nursing, Health Related Professions, Dentistry and graduate programs in the medical sciences will begin May 30 at 2:00 p.m. at the Medical Center.

Volunteers Accepted For UMC Drug Study

University of Mississippi Medical Center physicians are looking at a new way to treat patients who suffer pain caused by lumbar disc disease.

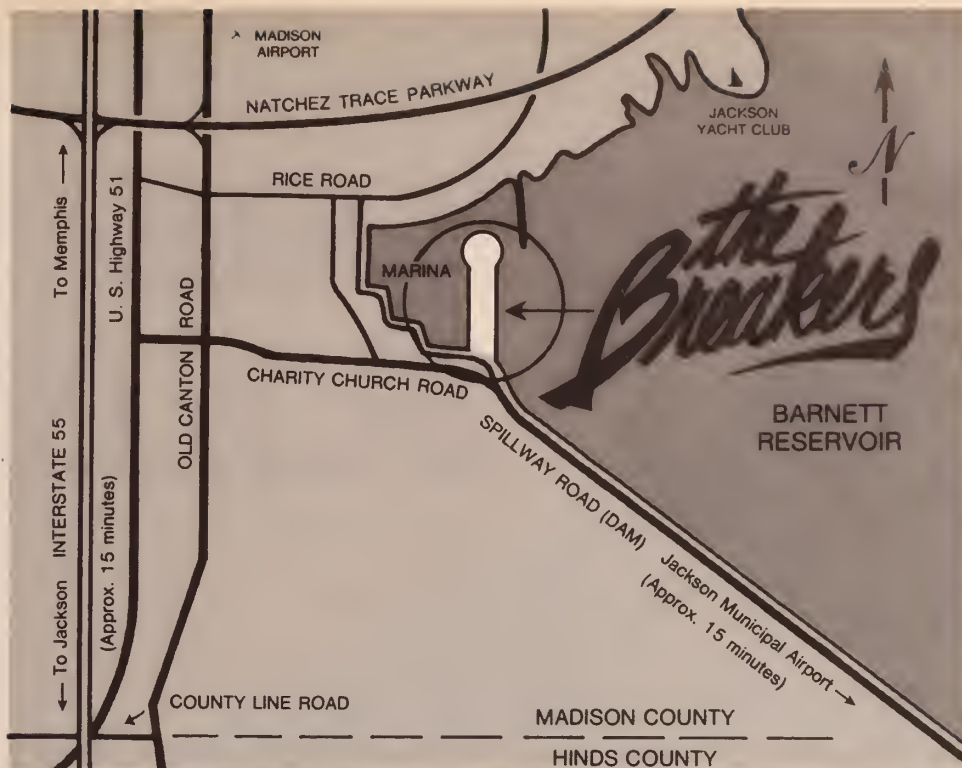
Under a study sponsored by Travenol Laboratories, physicians in the UMC Department of Neurosurgery are testing two drugs — CEI and Disease — both capable of dissolving a diseased disc.

The drug is injected directly into the nucleus of the disc. There is no damage to other discs and surgical removal of the diseased disc usually is not required.

The neurosurgery department is now accepting volunteers to participate in this drug study. Criteria for participation is rigid and volunteers will be carefully screened. Generally, the patients must never have had back surgery and must have exhausted conservative treatment methods.

For more information, contact the Department of Neurosurgery at the University of Mississippi Medical Center in Jackson. Call 987-5644 or 987-5712 weekdays before noon.





Someone has said that the three most important ingredients for an outstanding real estate investment are:

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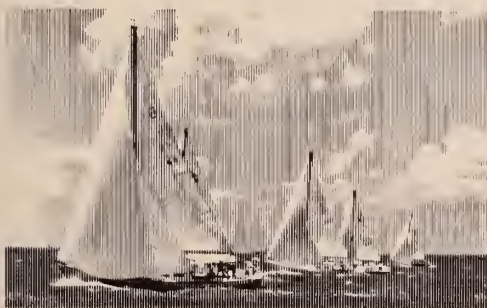
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The #1 physician-prescribed product for hemorrhoids and other common anorectal disorders**

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- ☐ **Astringent**, to help promote healing
- ☐ **Emollient**, for easier bowel movements and soothing relief of local trauma

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- ☐ **Soothes, cools, comforts** the irritation and itch of hemorrhoids and other common anorectal disorders
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*Meeting of Am Soc Colon / Rectal Surgeons, May 1980.

**Based on total prescriptions filled for hemorrhoidal preparations during the first three quarters of 1981. The National Prescription Audit, IMS America Ltd, Sept 1981.

*1981 data from leading marketing research organization.

ANUSOL-HC[®] Suppositories / ANUSOL-HC[®] Cream

Before prescribing, please see full prescribing information. A Brief Summary follows.

Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in external and internal hemorrhoids, proctitis, papillitis, cryptitis, and fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol[®] Suppositories or Ointment.

CONTRAINDICATIONS

Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

WARNINGS

The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

PRECAUTIONS

General

Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.

Pregnancy

See "WARNINGS."

Pediatric Use

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

DOSEAGE AND ADMINISTRATION

Anusol-HC Suppositories—Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

Store between 59°-86°F [15°-30°C]
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U. S. ARMY MEDICAL DEPARTMENT

First Year Graduate Medical Education

General

The Army Medical Department (AMEDD) operates the largest unified Graduate Medical Education (GME) program in the United States and probably in the free world. The AMEDD is one of the most mature educational systems in America. The AMEDD's purpose is to conduct quality GME in accredited programs of the specialties and numbers needed to produce a Medical Corps composition and strength that is appropriate to the needs of the total Army. Programs are conducted at all eight medical centers and at five community hospitals (Forts Benning, Belvoir, Bragg, Hood and Ord), but through outreach programs from these parent facilities many other Army hospitals are involved with residency training. All Army medical training programs are approved by the Council on Medical Education of the American Medical Association. Virtually all recognized residencies are offered. Each Army training hospital is affiliated with a leading nearby medical school. The range of cases, both in complexity and age, is virtually impossible to duplicate and medical records keeping is excellent. The well trained and competent ancillary support staff of an Army Hospital allows residents to spend a majority of their time treating patients, not doing chores. Also, we have designed our programs to ensure that our residents are used as full-time doctors—not part-time, tag-along onlookers. Total patient care responsibility is stressed.

Application

During the summer of 1983 the AMEDD will offer approximately 350 First Year Graduate Medical Education (FYGME) positions. Historically, most positions are filled by medical school graduates who were Army scholarship participants. However, the AMEDD actively seeks highly qualified civilian student applicants who have no current affiliations. FYGME programs are available in the flexible, categorical and categorical diversified categories.

Deadline for applications is 1 September 1982. All applicants are encouraged to also participate in the NIRMP. Selections for the Army FYGME Program will be announced in sufficient time for selectees to withdraw from the NIRMP.

To find out more information concerning this program, the eligibility criteria, service obligation, benefits, and application procedures contact:

North Mississippi

CPT Edward L. Lacy, MSC
1407 Union Avenue, Suite 407
Memphis, TN 38104
(901) 725-4445

South Mississippi

CPT Felipe Casso, MSC
144 Elk Place, Suite 1504
New Orleans, LA 70112
(504) 589-2373

An added complication... in the treatment of bacterial bronchitis*



Brief Summary.

Consult the package literature for prescribing information.
Indications and Usage: Cefclor® (cefactor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefactor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefactor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coomb testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy: Although no teratogenic or antiteratogenic effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefactor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Cefclor.

Hypersensitivity reactions have been reported in about 1.5

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁵

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthritis and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefclor® (cefactor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain: Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic: Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic: Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal: Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). (100281R)

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8:91, 1975.
2. Antimicrob. Agents Chemother., 11:470, 1977.
3. Antimicrob. Agents Chemother., 13:584, 1978.
4. Antimicrob. Agents Chemother., 12:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy, II 880 Washington, D.C. American Society for Microbiology, 1978).
6. Antimicrob. Agents Chemother., 13:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487 New York: John Wiley & Sons, 1979.

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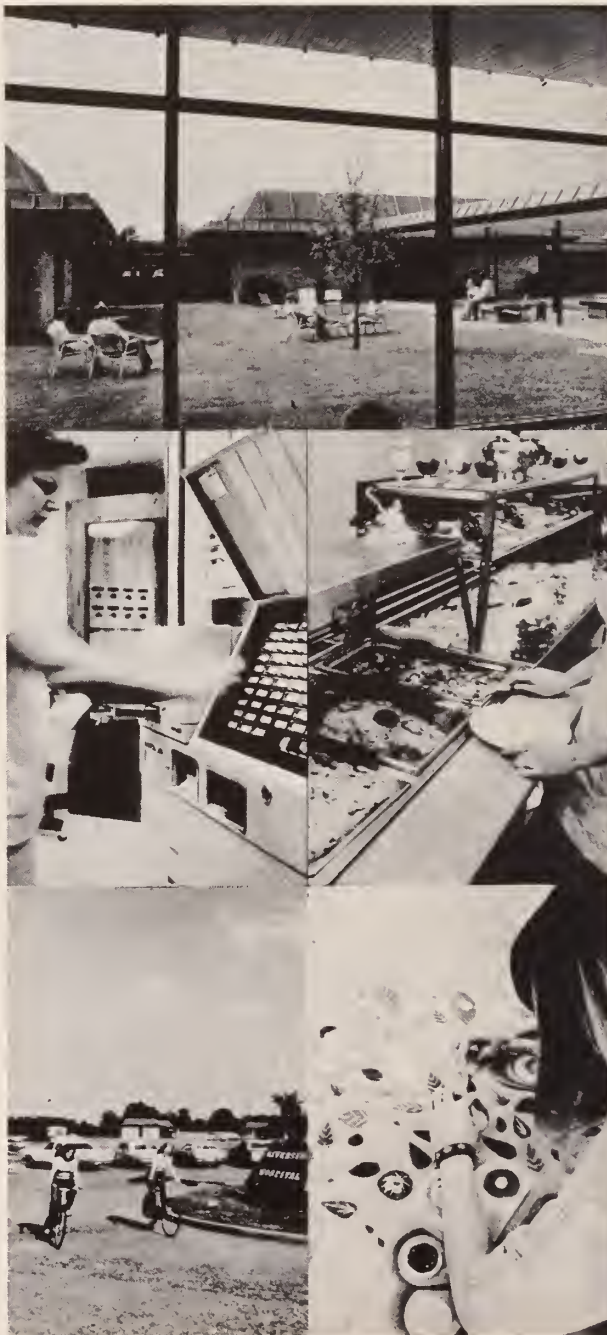
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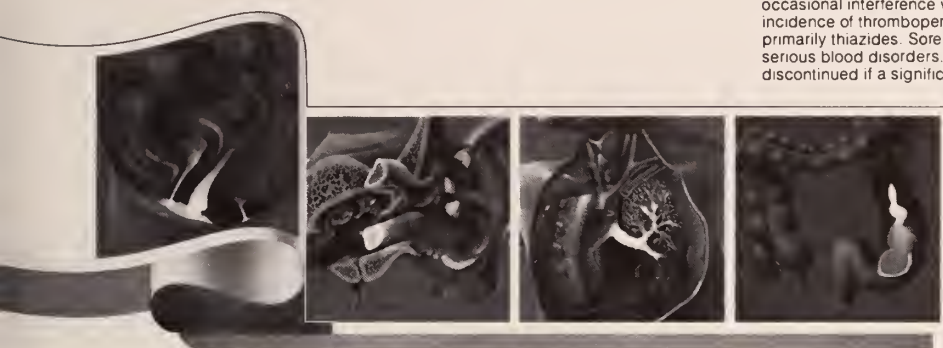
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in shigellosis... faster relief of diarrhea than with ampicillin²

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonia. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: General: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose[®] packages of 100; Prescription Paks of 20 and 28. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose[®] packages of 100; Prescription Paks of 40. Pediatric Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).



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1. Rubin RH, Swartz MN: *N Engl J Med* 303 426-432, Aug 21, 1980. 2. Data on file, Medical Department, Hoffmann-La Roche Inc.

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Please see previous page for summary of product information.

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**Malignant Mixed Tumor
Of the Gallbladder**

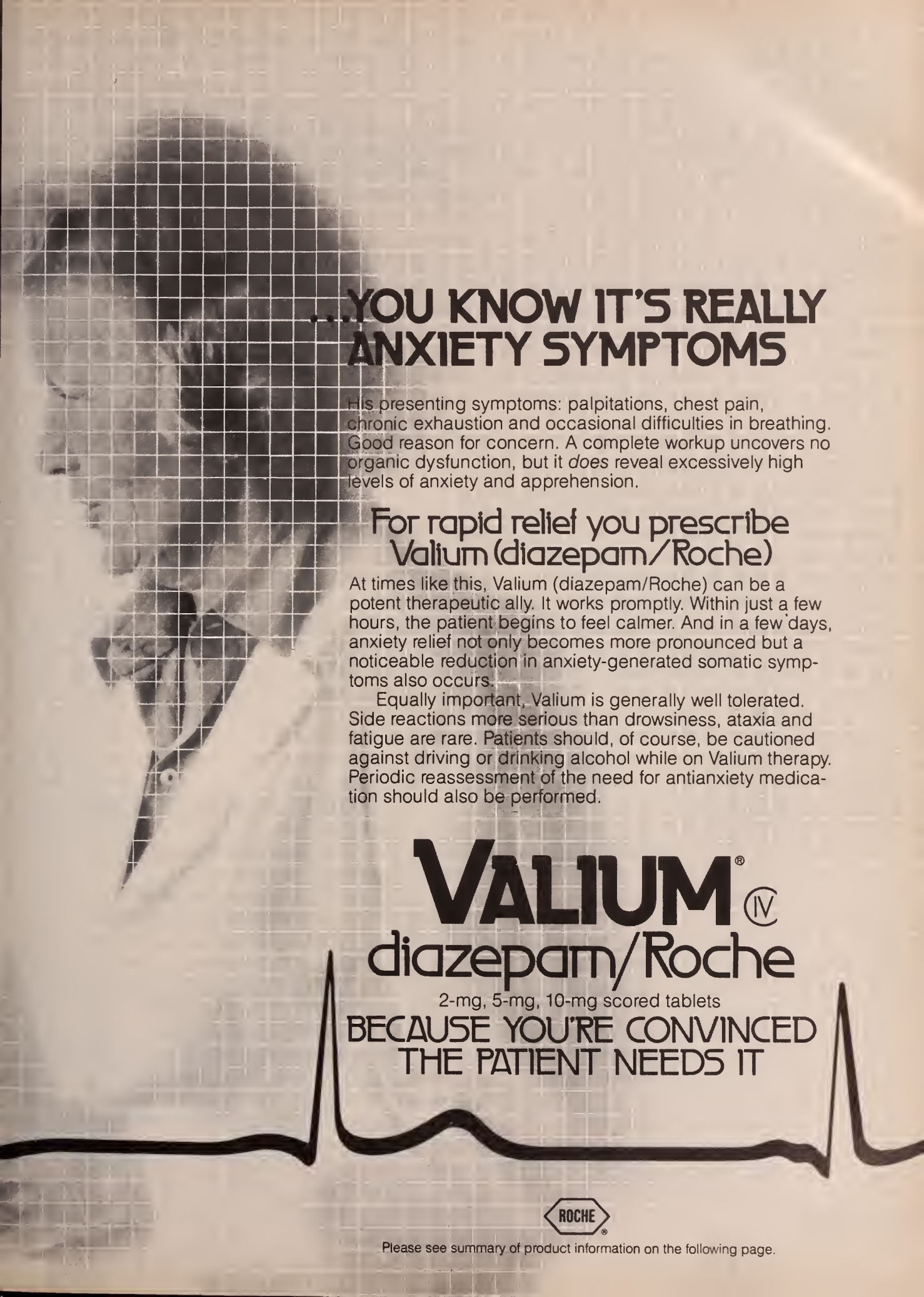
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2-mg, 5-mg, 10-mg scored tablets

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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication. Abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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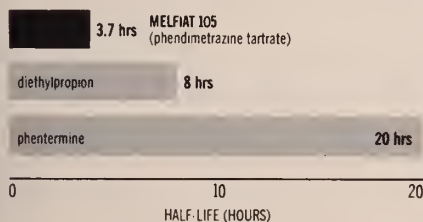
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(phendimetrazine tartrate)
Sustained-Release Capsules 105 mg

Because MELFIAT 105 is in a sustained-release capsule.

MELFIAT 105 provides your patients with continuous drug delivery for appetite control that lasts throughout the day and helps to eliminate compulsive snacking and overeating at meals. In addition, the sustained-release capsule form maintains more constant blood levels of MELFIAT 105... without peaks and valleys.

Because MELFIAT 105 offers convenient, once-a-day dosage.

MELFIAT 105 is available in a convenient capsule containing 105 mg. The simple morning dosage regimen is designed to encourage compliance, minimizing the chance of missed doses and assuring optimum therapeutic results.

Because MELFIAT 105 is from Reid-Provident Laboratories, Inc. Reid-Provident has the highest standards of quality to assure that only the finest products reach you. An advisory board of research scientists, physicians, pharmacists, and other technical staff continually review existing products and new product proposals to make sure that the latest pharmaceutical technology is used in their design and manufacture. That's because Reid-Provident is committed to you and your patients.

For more information please write to Reid-Provident Laboratories, Inc.
640 Tenth Street, N.W.
Atlanta, Georgia 30318

References: 1. Sheu YS, Ferguson JA, Cooper JR: Evaluation of the Abuse Liability of Diethylpropion, Phendimetrazine, and Phentermine, unclassified document ADAMHA, HHS, Office of Medical and Professional Affairs, NIDA, 1980.
2. Douglas JG, Munro JF: The role of drugs in the treatment of obesity, *Drugs* 21:362-373, 1981.

MELFIAT® 105 UNICELLES® III

(phendimetrazine tartrate) 105 mg Sustained-Release Capsules

INDICATIONS AND USAGE: Melfiat® 105 (phendimetrazine tartrate) is indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class (See CLINICAL PHARMACOLOGY) should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result).

WARNINGS: Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should be discontinued. Phendimetrazine tartrate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

Drug Dependence: Phendimetrazine tartrate is related chemically and pharmacologically to the amphetamines. Amphetamines and related stimulant drugs have been extensively abused, and the possibility of abuse of phendimetrazine tartrate should be kept in mind when evaluating the desirability of including a drug as part of a weight-reduction program. Abuse of amphetamines and related drugs may be associated with intense psychological dependence and severe social dysfunction. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high-dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG, manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia.

USAGE IN PREGNANCY: The safety of phendimetrazine tartrate in pregnancy and lactation has not been established. Therefore, phendimetrazine tartrate should not be taken by women who are or may become pregnant.

USAGE IN CHILDREN: Phendimetrazine tartrate is not recommended for use in children under 12 years of age.

PRECAUTION: Caution is to be exercised in prescribing phendimetrazine tartrate for patients with even mild hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of phendimetrazine tartrate and the concomitant dietary regimen. Phendimetrazine tartrate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage.

ADVERSE REACTIONS: Cardiovascular: Palpitation, tachycardia, elevation of blood pressure.

Central Nervous System: Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache; rarely psychotic episodes at recommended doses.

Gastrointestinal: Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances.

Allergic: Urticaria.

Endocrine: Impotence, changes in libido.

OVERDOSAGE: Manifestations of acute overdosage with phendimetrazine tartrate include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states.

Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma. Management of acute phendimetrazine tartrate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Acidification of the urine increases phendimetrazine tartrate excretion. Intravenous phentolamine (Regitine) has been suggested for possible acute, severe hypertension, if this complicates phendimetrazine tartrate overdosage.

DOSAGE AND ADMINISTRATION: Since Melfiat® 105 (phendimetrazine tartrate) 105 mg is a sustained-release dosage form, limit to one sustained-release capsule in the morning. Melfiat® 105 (phendimetrazine tartrate) is not recommended for use in children under 12 years of age.

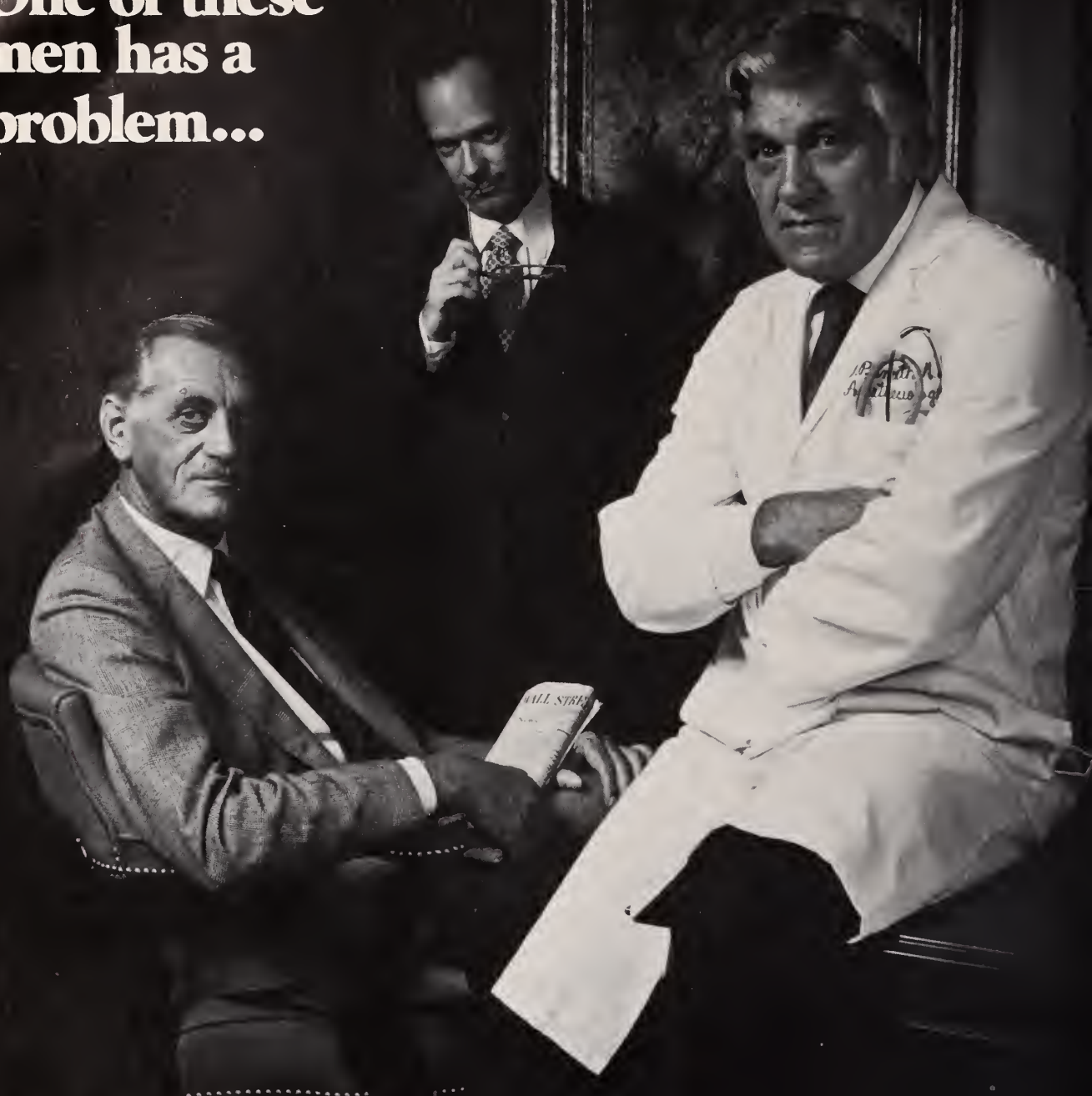
HOW SUPPLIED: Each orange and clear sustained-release capsule contains 105 mg phendimetrazine tartrate in bottles of 100.

CAUTION: Federal law prohibits dispensing without prescription.



Reid-Provident Laboratories, Inc.
Atlanta, Georgia 30318

**One of these
men has a
problem...**



and so do his family and colleagues.

There are special considerations in the treatment of professionals and executives who are impaired through dependency on drugs or alcohol: not because the patient or his addiction is different from others, but because of the strict sanctions imposed by the public and professional communities.

The A & D Center specializes in the treatment of the professional or executive who is chemically dependent. Treatment at the Center is designed to provide complete medical and counseling services, with care, dignity, and confidentiality for the patient. Family care and aftercare are emphasized, and specific plans are made for the re-entry process.

The A & D Center, located at the modern, 162-bed Doctors Hospital in Jackson, offers a 96-hour evaluation program, with the total inpatient treatment program extending for thirty days. For further information on the A & D Center, contact:



Doctors Hospital A & D Center
2969 University Drive
Jackson, Mississippi 39216
(601) 982-8321

NEWSLETTER

May 1982

Dear Doctor:

The Mississippi Legislature passed a number of bills of interest to the medical profession. The Medical Practice Act was amended to provide a penalty, effective in 1983, for late renewal of a license to practice medicine. Workmen's Compensation claimants may now select their own physician for determination of ability to work. The Mississippi Medicaid Commission was authorized to establish a reimbursement schedule for physicians' services.

Another bill makes it illegal to prescribe amphetamines for the treatment of obesity. Under other legislation passed during the 1982 session, the per diem reimbursement to public hospitals providing care for charity patients was increased to \$100. The previous per diem rate was \$25.

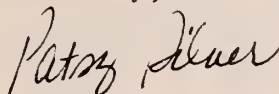
Physicians' fees rose at a rate of 1.0% in February, exceeding the percentage increases in the CPI all-items component (0.3%) and the all-services component (0.4%). Prescription drug charges also rose 1.0%, but hospital room charges rose by only 0.8%, a substantial drop from the 1.9% increase in January. In the past 12 months the physicians' services index has risen 10.8%.

President Reagan has not made a final decision on the proposed pro-competition national health plan, according to HHS Secretary Schweiker. He questioned the accuracy of a published report that said the Administration had abandoned major elements of the plan, including placing a ceiling on the amount of private health insurance costs that businesses can deduct.

The AMA has backed more explicit health warnings on cigarette packages and in advertisements and also told the House Commerce Subcommittee on Health that the effectiveness of rotating health warning labels should be evaluated after a time. The AMA reported development of material for physicians to use in assisting patients who wish to stop smoking.

Medical organizations have renewed their attack on the Administration's plan to notify parents of teenage girls who receive prescription contraceptives from federally-funded clinics. One prediction is that 100,000 pregnancies will result in this high-risk group, since many teenagers will not seek birth control services if confidentiality is not assured.

Sincerely,



Patsy Silver
Managing Editor

More
physicians
are coming to
MMFES
because MMFES does
more for physicians.

The active and involved physician has to rely on comprehensive insurance programs tailored to fit the day-to-day special needs of his profession.

One of these special needs is malpractice insurance. MMFES is a non-profit Mississippi Corporation sponsored by the Mississippi State Medical Association and

directed by Mississippi physicians. MMFES offers comprehensive coverage on three types of malpractice insurance policies and it'll probably cost you less than other plans.

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their
homes

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NEOSPORIN® Ointment (POLYMYXIN B-BACITRACIN-NEOMYCIN)

- Broad-spectrum antibacterial
- Handy applicator tip

DESCRIPTION: Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs, in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. Prophylactically the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neo-



mycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section). Complete literature available on request from Professional Services Dept. PML.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Motrin[®]

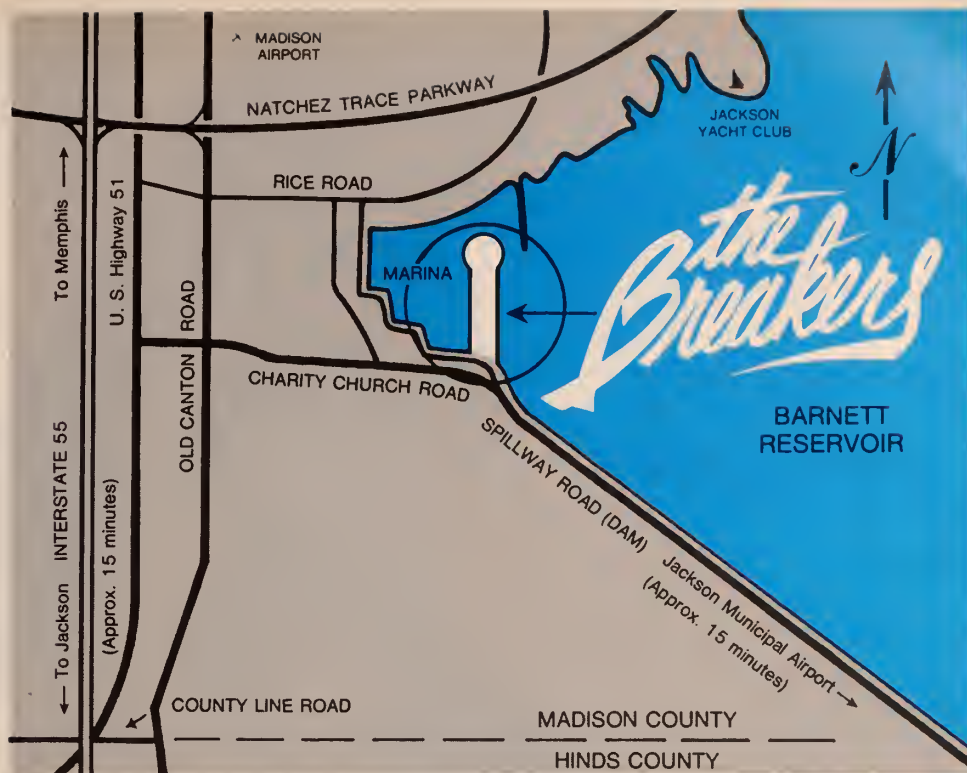
ibuprofen, Upjohn

600 mg Tablets



More convenient for your patients

Upjohn



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In life, there is a certain joy and anticipation in watching for one's ship to come in. When your ship does make it in, it means good things for you and yours — happiness, contentment, peace-of-mind, security, a sense of well-being. And there's no better place for your ship to come in than at The Breakers. Here is luxurious waterfront living at its very best. Surrounded by year-round deep water, you'll enjoy a feeling of quiet, carefree isolation from the ordinary world. Yes, life is good and your days and nights are beautiful at The Breakers — where your ship comes in several times a day **every season of the year**. Write for color brochure or come by for a visit soon.



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Mississippi's only physician-oriented sports medicine and physical fitness facility is now available to assist you in treating sports injuries and developing prescription exercise programs for patients of all ages. The Sports Medicine and Fitness Center is an open-staff facility, with a consulting staff in related specialties. For the treatment and rehabilitation of patients who have suffered traumatic sports injuries on the playing field, or recreational athletes who sometimes exceed their physical limits, consider the Sports Medicine and Fitness Center as an extension of your practice. For further information on facilities and programs offered, contact:

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Jackson,
Mississippi 39208*

DATELINE

Aspirin and
Reye's Syndrome

Evanston, IL - The American Academy of Pediatrics has endorsed a statement by its infectious disease committee urging doctors to avoid aspirin when treating fevers in children with influenza or chickenpox. The reported association of aspirin with the development of Reye's syndrome has caused concern and confusion since the Centers for Disease Control issued a recent warning. The April issue of Pediatrics has a seven-page analysis of the question by the AAP committee.

AMA Urges Repeal
Of Planning Act

Chicago, IL - The American Medical Association testified for the repeal of the National Health Planning and Resources Development Act of 1974 (PL 93-641). In its testimony, the AMA indicated its support for voluntary, locally-based health planning and outlined principles on voluntary health planning the association has developed. The California Hospital Association also supported repeal of the law, but other witnesses favored retaining the law.

Administrators
Express Concerns

Cleveland, OH - Sixty percent of hospital administrators in a recent survey want a completely new system for payment under Medicare - a prospective payment system that sets fees in advance - believing that such a system has built-in incentives for efficiency. Fifty-three percent of those surveyed think the government should ask the elderly to pay a larger share of their health care costs. Four out of 10 administrators feared they would not be able to compete by 1985.

AMA Publishes Three
Consumer Books

Chicago, IL - The AMA's Home Health Library was launched last month with the publication of the first three consumer trade volumes geared toward individual self-education and preventive care. The books are WomanCare, HeartCare and BackCare. Each volume sells for \$12.95. The books are based on a consensus of the most up-to-date medical opinion from consultants all over the country, the AMA says, and offer sound, sensible advice at a time when much information is based on fads.

1982 AMA-ERF
Funds Awarded

Chicago, IL - A total of \$1.5 million has been channeled to the nation's medical schools in grants from the AMA's Education and Research Foundation. AMA Auxiliary units have taken the lead in bringing in funds for the projects of the foundation, which has raised more than \$36 million over the years. Amounts of the 1982 grants vary, but virtually every school in the U.S. and most schools in Canada received some funds. Jackson's University Medical Center received \$24,966.85.

An added complication... in the treatment of bacterial bronchitis*



Brief Summary.

Consult the package literature for prescribing information.

Indications and Usage: Cefaclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefaclor.

Contraindication: Cefaclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cefaclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coomb testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefaclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefaclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistix® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Cefaclor.

Hypersensitivity reactions have been reported in about 1.5

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefaclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefaclor.⁷

Cefaclor®

cefaclor

Pulvules®, 250 and 500 mg

percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthritis, and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefaclor® (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). (100281R)

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefaclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8:91, 1975.
2. Antimicrob. Agents Chemother., 11:470, 1977.
3. Antimicrob. Agents Chemother., 13:584, 1978.
4. Antimicrob. Agents Chemother., 12:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), 11:880. Washington, D.C. American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 13:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

200065

ALL FOR ONE ONE FOR ALL



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Alexandre Dumas'
The Three Musketeers
and D'Artagnan

ONE FOR ALL – One tablet treats pinworm
in any patient, regardless of age or body weight.*
Obviates need to calculate individual dosages.

A single tablet eradicates pinworm in 95% of patients.

*Contraindicated in pregnant women and in persons who have shown hypersensitivity to the drug.

VERMOX[®] CHEWABLE TABLETS
(mebendazole)



JANSSEN
PHARMACEUTICA

The #1 anthelmintic for pinworms and many other worm infestations

Please see complete Prescribing Information on adjacent page.

VERMOX[®] CHEWABLE TABLETS

(mebendazole)

R_x

Vermox
Tabs #4
Sig 1 tab
each family
member



DESCRIPTION VERMOX (mebendazole) is methyl 5-benzoylbenzimidazole-2-carbamate.

ACTIONS VERMOX exerts its anthelmintic effect by blocking glucose uptake by the susceptible helminths, thereby depleting the energy level until it becomes inadequate for survival. In man, approximately 2% of administered mebendazole is excreted in urine as unchanged drug or a primary metabolite. Following administration of 100 mg of mebendazole twice daily for three consecutive days, plasma levels of mebendazole and its primary metabolite, the 2-amine, never exceeded 0.03 µg/ml and 0.09 µg/ml, respectively.

INDICATIONS VERMOX is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (common roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections. Efficacy varies as a function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Whipworm	Common Roundworm	Hookworm	Pinworm
 cure rates				
mean	68%	98%	96%	95%
(range)	(61-75%)	(91-100%)	—	(90-100%)
egg reduction				
mean	93%	99.7%	99.9%	—
(range)	(70-99%)	(99.5%-100%)	—	—

CONTRAINDICATIONS VERMOX is contraindicated in pregnant women (see Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

PRECAUTIONS **PREGNANCY:** VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

ADVERSE REACTIONS Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

DOSAGE AND ADMINISTRATION The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time. For the control of common roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days. If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

HOW SUPPLIED VERMOX is available as chewable tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets. VERMOX (mebendazole) is an original product of Janssen Pharmaceutica, Belgium.

US Patent 3,657,267
December 1979

Committed to research...
because so much remains to be done.

Tableted by Janssen Pharmaceutica, Beerse, Belgium for



JANSSEN
PHARMACEUTICA

New Brunswick, New Jersey 08903

Cyclapen[®]-W (cyclacillin)

Indications

Cyclacillin has less *in vitro* activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*), *H. influenzae*, and Group A beta-hemolytic streptococci
Acute exacerbation of chronic bronchitis caused by *H. influenzae*^{*}

^{*}Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure: Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN [*]
Respiratory Tract		
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1. Ginsburg CM, McCracken GH Jr, Zweighaft TC, Clahsen JC: Comparative pharmacokinetics of cyclacillin and amoxicillin in infants and children. *Antimicrob Ag Chemother* 19:1086-1088 (June) 1981.

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ORIGINAL PAPERS

Malignant Mixed Tumor of The Gallbladder

BRIAN R. CARLSON, M.D.,* and FRANK T. McPHERSON, M.D.
Vicksburg, Mississippi

FEW RECORDED CASES of biliary malignant neoplasms containing elements of multiple germ layers exist. These tumors have been referred to as malignant mixed tumors or carcinosarcomas.^{1, 2, 3, 4} We describe an example of malignant mixed tumor of the gallbladder and briefly review the pertinent literature.

Case Report

A 75-year-old black female was admitted to the hospital because of upper abdominal pain and jaundice of one week duration. Physical examination revealed icterus and an obvious mass in the right upper quadrant of the abdomen. No other masses were palpable. Abnormal laboratory data included bilirubin elevated more than eightfold, alkaline phosphatase elevated more than threefold, and SGOT 61 mU/ml (normal 7 to 40). A sonogram of the abdomen showed a very large mass in the right upper quadrant of the abdomen at the inferior margin of the liver but extrinsic to the liver.

An exploratory laparotomy was performed. The gallbladder contained a large necrotic mass fixed to the liver, transverse colon, and duodenum. The gallbladder was opened and two calculi measuring 2.5 and 2.3 cm in diameter were removed. A metastatic nodule to the serosa of the liver showed malignant tumor. A resection was not feasible. Biopsies of the

The authors report an unusual case of malignant mixed tumor of the gallbladder in which components of adenocarcinoma, chondrosarcoma, squamous cell carcinoma, and undifferentiated sarcoma could be identified. The authors note that few previous reports of this tumor exist. Malignant mixed tumor of the gallbladder appears to affect adult men and women and may be associated with cholelithiasis.

gallbladder were performed; the gallbladder was closed and a drain placed in the area.

Postoperatively the bilirubin dropped to 5.0 mg/dl with a direct of 3.3 mg/dl. This decrease from preoperative levels was thought to be due to a fistula which developed between the tumor mass and a right upper quadrant incision. Postoperatively the patient pursued a rapidly downhill course and died on the 25th postoperative day. An autopsy was performed.

Pathologic Findings

At necropsy the tumor arose in the neck of the gallbladder and extended to the porta hepatis, adjacent liver, adjacent duodenum, and transverse colon. The common bile duct was relatively spared and involved only at its junction with the cystic duct and hepatic duct. Metastases were present in the right pleura, serosal surface of the liver, and diaphragm. The histologic changes in the tumor removal at the time of exploratory laparotomy and in the tumor at necropsy were similar.

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Microscopic examination of the tumor revealed four distinct patterns. Much of the tumor was composed of undifferentiated sarcomatous stroma containing spindle cells with large dark nuclei and eosinophilic cytoplasm (see Figure 1). Focally the sarcomatous tissue had differentiated along the lines of malignant cartilage (see Figure 2). A distinct adenocarcinoma component could be identified (see Figures 3 and 4). In some areas neoplastic glands were embedded in the sarcomatous stroma, and in other areas the adenocarcinoma had a papillary appearance. The cells forming the neoplastic glands tended to be columnar shaped with very pleomorphic nuclei. The cytoplasm of these cells was eosinophilic in some areas and clear in other areas. Nests of moderately well differentiated squamous cell carcinoma were present in the tissue (see Figure 5). The metastases had a predominantly sarcomatous appearance.

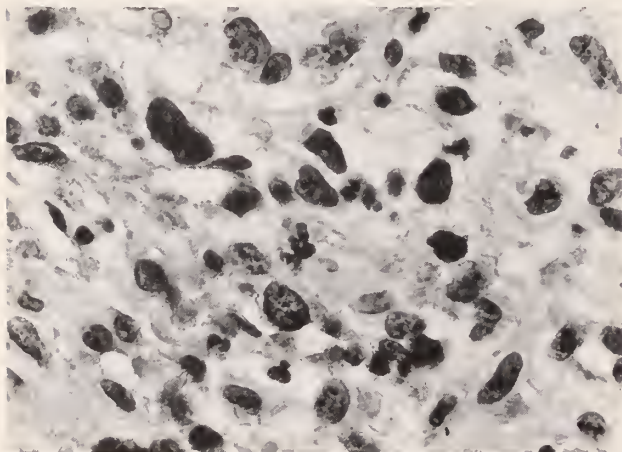


Figure 1. Sarcomatous hypercellular tissue with large dark nuclei. Hematoxylin-Eosin, $\times 400$.

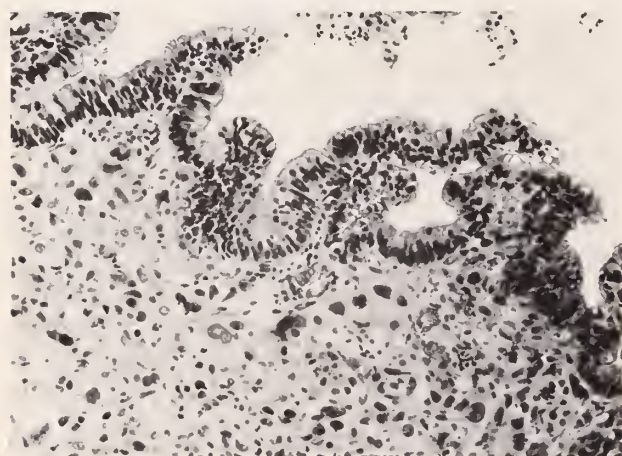


Figure 3. Neoplastic epithelial cells lining sarcomatous stroma. Hematoxylin-Eosin $\times 100$.

Discussion

Primary malignant tumors of the gallbladder constitute less than 1% of all malignancies in the United States.⁵ The biliary neoplasms are usually adenocarcinomas and much less frequently squamous cell carcinomas.^{3, 5, 6} Unusual types of gallbladder carcinoma include oat cell carcinoma, giant cell adenocarcinoma, intestinal type adenocarcinoma, and adenocarcinoma with choriocarcinoma-like areas.⁵ Sarcomas are rare in the gallbladder.^{5, 6}

Malignant mixed tumors of the gallbladder are quite rare. A review of the literature reveals three cases of gallbladder tumors designated malignant mixed tumors.^{1, 2, 3} Two cases have been described as containing distinct components of adenocarcinoma and sarcomatous stroma including fibrosarcoma and chondrosarcoma.^{2, 3} The present case includes these components with an additional element of extensive squamous cell carcinoma. Edmondson de-



Figure 2. Malignant cartilaginous tissue. Hematoxylin-Eosin $\times 100$.

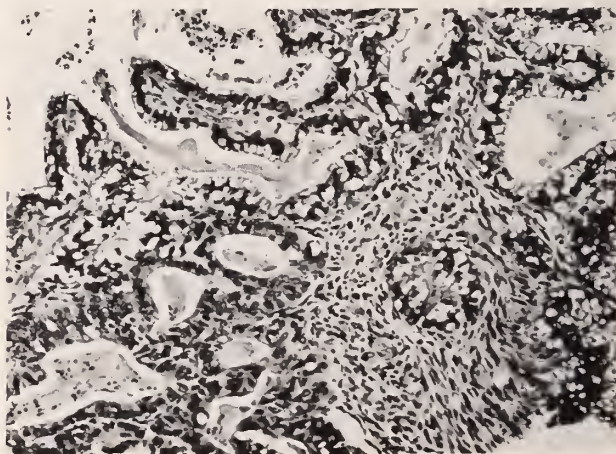


Figure 4. Adenocarcinoma component containing some neoplastic cells with clear cytoplasm. Hematoxylin-Eosin $\times 100$.

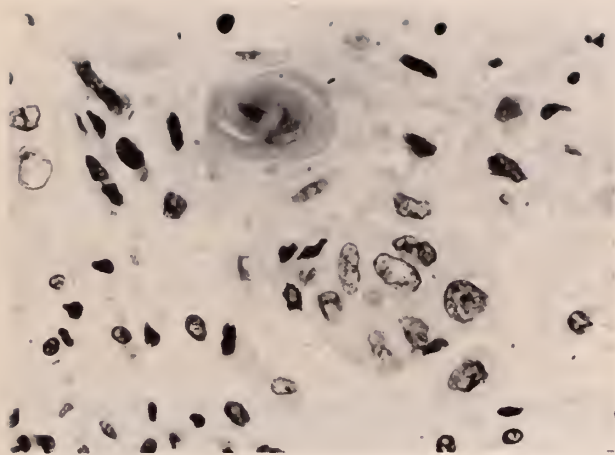


Figure 5. Focus of squamous cell carcinoma. Hematoxylin-Eosin $\times 400$.

scribed a malignant mixed tumor of the common bile duct containing foci of adenocarcinoma, squamous cell carcinoma, undifferentiated sarcoma, and islands of malignant cartilage cells very similar to our case.¹ He also described a carcinosarcoma of the gallbladder composed of well differentiated adenocarcinoma and spindle cell sarcoma. Mehrotra et al described a carcinosarcoma composed of sarcoma with elements of adenocarcinoma and extensive squamous metaplasia.⁴ An apparently benign mixed tumor was reported by Higgins et al, with significant histologic difference from the present case.⁷

Available data indicate the prognosis is extremely poor with a rapidly downhill clinical course. Early diagnosis is difficult, and the tumor has been far-advanced at the time of operation.

As is usually the case for human neoplasms, the precise cause or causes of malignant tumors of the gallbladder are unknown. Cholelithiasis has been associated with the development of carcinoma of the gallbladder.⁸ It is thought that repeated injury and repair of the gallbladder mucosa by mechanical irritation and inflammation may eventually end in

malignant tumor.⁸ However, in approximately 10% of patients with gallbladder carcinoma gallstones are absent,⁸ and cholelithiasis cannot be the sole etiological agent. Cholelithiasis has been recorded in the two previously recorded cases of malignant mixed tumor of the gallbladder,^{2, 3} as well as the presently recorded case. Two of the previously reported cases of carcinosarcoma of the gallbladder also described cholelithiasis.^{1, 4} No mention of the presence or absence of cholelithiasis was made in one additional case of malignant mixed tumor.¹

Although malignant mixed tumors of the liver have been reported numerous times in both children and adults^{9, 10} reports of malignant mixed tumors of gallbladder are rare. The few initial reports indicate malignant mixed tumor of the gallbladder affects adult men and women and may be associated with cholelithiasis.

★★★

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References

1. Edmundson, H. A.: Tumors of the gallbladder and extrahepatic bile ducts, Atlas of Tumor Pathology. Washington, D. C., Armed Forces Institute of Pathology, Sect. VII, Fasc. 26:79-83, 1967.
2. Higgs, W. R., Mocega, E. E. and Jordan, P. H.: Malignant mixed tumor of the gallbladder. *Cancer* 32:471-475, August, 1973.
3. Mansori, K.S. and Sang, Y. C.: Malignant mixed tumor of the gallbladder. *Am. J. Clin. Pathol.* 73:709-711, May, 1980.
4. Mehrotra, T. N., Gupta, S. C. and Naithani, Y. P.: Carcinosarcoma of the gallbladder. *J. Pathol.* 104:145-148, June, 1971.
5. Albores-Saavedra, J., Cruz-Ortiz, H., Alcantara-Vazques, A. and Henson, D. E.: Unusual types of gallbladder carcinoma. *Arch. Pathol. Lab. Med.* 105:287-293, June, 1981.
6. Kirshbaum, J. D. and Kozoll, D. D.: Carcinoma of the gallbladder and extrahepatic bile ducts. *Surg. Gynecol. Obstet.* 73:740-754, November, 1941.
7. Higgins, G. A. and Turner, J. A.: Mixed tumor of the gallbladder. *Arch. Surg.* 78:173-176, January, 1959.
8. Tanga, M. R. and Ewing, J. B.: Primary malignant tumors of the gallbladder: Report of 43 cases. *Surg.* 67:418-426, March, 1970.
9. Edmundson, H. A.: Tumors of the liver and intra-hepatic bile ducts, Atlas of Tumor Pathology. Washington, D. C. Armed Forces Institute of Pathology, Sect. VII, Fasc. 25:152-158, 1958.
10. Blanding, J. D.: Mixed malignant tumor of the liver in an adult. *Arch. Path.* 86:108-110, July, 1968.

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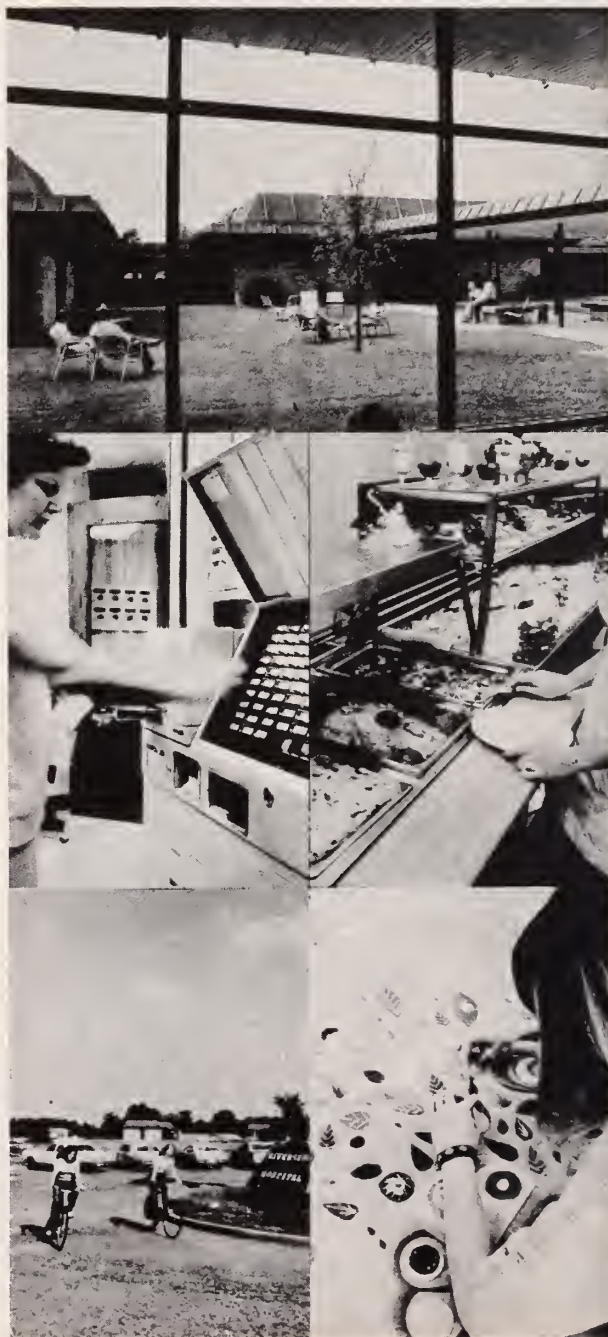
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Splenic Vein Thrombosis: A Curable Form of Portal Hypertension

RUSSELL CUMMINGS, M.D. and SESHADRI RAJU, M.D.

Jackson, Mississippi

UPPER GASTROINTESTINAL BLEEDING in alcoholic patients is usually linked with liver disease, generalized portal hypertension, varices, and occasionally peptic ulcer disease. Splenic vein thrombosis is an infrequent cause of segmental portal hypertension and usually is seen in the same population of alcoholic patients with recurrent pancreatitis. In splenic vein thrombosis, portal pressures are usually normal and portosystemic shunts are not feasible; splenectomy is usually curative. Hence, it is important to recognize this form of portal hypertension when it occurs. Liver biopsy, hepatic wedge pressure measurement, and mesenteric arteriography or spleno-portogram usually provide the diagnosis.

Case I

K. L. is a 40-year-old black female with a long history of alcohol abuse and documented pancreatitis requiring two previous hospital admissions. She presented three years after her first admission with another episode of pancreatitis and upper gastrointestinal bleeding. Esophagogastroduodenoscopy was performed with a bleeding site thought to be present in the duodenum. A vagotomy and pyloroplasty was performed. Although no bleeding source could be found at operation, the patient had no further bleeding and was discharged after an uneventful postoperative course. She did well for approximately three weeks when she again presented with hematemesis and melena. Endoscopy at that time revealed numerous large gastric varices in the fundus of the stomach. The bleeding ceased with conservative management and a workup for portal hypertension was begun. Liver function profile and biopsy were normal. Free hepatic vein pressure was 6 cm H₂O with hepatic wedge pressure of 7 cm H₂O and vena cava pressure of 3 cm H₂O. A delayed venous phase superior mesenteric and celiac artery injection showed splenic vein thrombosis with a patent superior mesenteric and portal vein; massive

gastric varices were present. Surprisingly, the spleen did not appear massively enlarged clinically or radiographically. A spleno-portogram was obtained and splenic pulp pressure was found to be 31 cm H₂O. Again splenic vein thrombosis was noted with large gastric varices (see Figure 1).

The patient was prepared for surgery, and at laparotomy only a mildly enlarged spleen was found. However, numerous dilated veins were encountered in the gastrosplenic omentum and along the greater curvature of the stomach. Within the lesser sac and omentum, areas of fat necrosis and calcification secondary to pancreatitis were evident. The spleen was removed uneventfully. Dissection of the specimen confirmed splenic vein thrombosis with organization of the thrombus. The patient was discharged one week later, following an uneventful postoperative course.

Case II

B. H., a 66-year-old black male, was admitted to the hospital immediately after two episodes of hematemesis associated with mild cramping epigastric pain. He had experienced a weight loss of 20 pounds during the previous six months, but his history was negative for melena, alcohol abuse, pancreatitis or peptic ulcer disease.

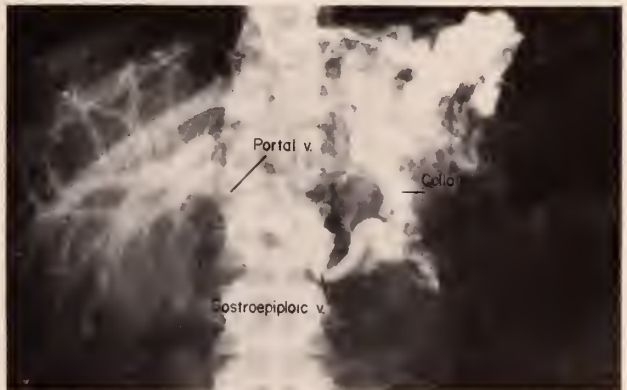


Figure 1. Spleno-portogram of patient with splenic vein thrombosis. The pulp pressure was elevated. Numerous collaterals are seen in the gastrosplenic omentum.

From the Department of Surgery, University Medical Center, Jackson, MS.

Splenic Vein Thrombosis/Cummings and Raju

On admission his blood pressure was 110/70 supine and 70/50 sitting. His pulse rate was 110. Initial hematocrit was 31. The remaining laboratory tests were all entirely within normal limits. He had a vague palpable mass in his epigastrium. He was admitted to the Intensive Care Unit and placed on intravenous Vasopressin, Cimetadine and ice water lavage. He underwent gastroscopy on the night of admission which revealed a ½ cm prepyloric ulcer which was not actively bleeding; there was also apparent erosion at the gastroesophageal junction. He received blood transfusions and the bleeding stopped. However, rebleeding began two days later; on repeat endoscopy, bleeding gastric and esophageal varices were noted. Mesenteric arteriography revealed splenic vein thrombosis. Venous phase angiography also showed large gastric and esophageal varices. Vena caval and wedge hepatic vein pressures were 8 and 9 cms H₂O, respectively. A computerized axial tomographic scan was performed, which indicated a mass in the body and tail of the pancreas consistent with carcinoma or pancreatitis. A liver biopsy showed no evidence of cirrhosis. Because of continual hemorrhage, the patient underwent exploratory surgery, and a large tumor mass involving the body and tail of the pancreas was identified, as well as peritoneal and diaphragmatic tumor implants. Intra-operative pressure measurements in the left gastroepiploic vein revealed a venous pressure measurement of 32 cms H₂O, while intra-operative portal pressure measurement was 8 cms H₂O. A splenectomy was performed, which was well tolerated by the patient. In two months of followup, the patient has had no recurrent upper gastrointestinal hemorrhage. Current treatment consists of 5-Fluorouracil chemotherapy and Cimetidine for his peptic ulcer.

Comments

Splenic vein thrombosis is most commonly seen in patients with alcoholic pancreatitis,¹ but it may also be seen as a complication of suppurative, traumatic, or hereditary pancreatitis.² Isolated cases have been reported secondary to tumors^{3, 4} and to retroperitoneal fibrosis.⁵ With obstruction of the splenic vein, pressure increases in the venous system proximal to the obstruction causing congestion within the spleen and increased pulp pressure. This leads to enlargement of the numerous collateral veins,

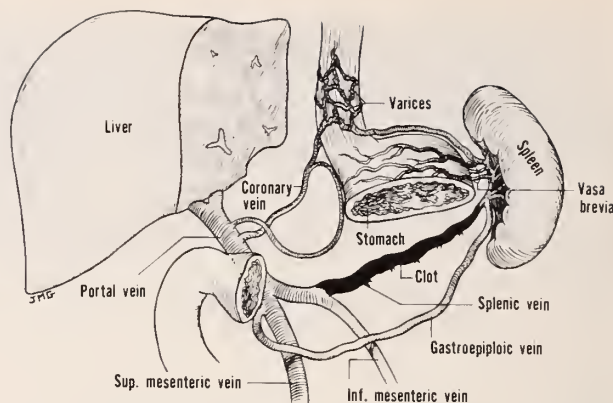


Figure 2. Venous collaterals in the presence of splenic vein thrombosis. Engorgement of the veins accompanying vasa brevia may result in esophageal varices due to collateral venous drainage.

namely the vasa brevia or short gastric veins, which in turn leads to gastric and esophageal varices (see Figure 2). The clinical picture is characteristic and should be suspected in every patient who presents with variceal bleeding in the absence of any liver disease and normal wedge pressures. Definitive diagnosis is made by angiography or splenoportography. The latter technique has the advantage of allowing one to measure splenic pulp pressure, which is elevated. Splenectomy cures portal hypertension in patients with isolated thrombosis of the splenic vein. ★★★

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References

1. Salam, A. A., Warren, W. D. and Tyras, D. H.: Splenic vein thrombosis: A diagnosable and curable form of portal hypertension. *Surgery* 74:961, 1973.
2. McElroy, R. and Christiansen, P. A.: Hereditary pancreatitis in a kinship associated with portal vein thrombosis. *Am. J. Med.* 52:228, 1972.
3. Marks, L. H., Weingarten, B. and Gent, G.: Carcinoma of the tail of the pancreas associated with bleeding gastric varices and hypersplenism. *Ann. Intern. Med.* 37:1077, 1952.
4. Hurwitt, E. W., Altman, S. F., Gent, G. R. et al: Gastrointestinal bleeding due to splenic vein obstruction by pancreatic tumors. *Arch. Surg.* 68:7, 1954.
5. Lavender, S., Lloyd-Davies, R. W. and Thomas, M. L.: Retroperitoneal fibrosis causing localized portal hypertension. *Br. Med. J.* 3:627, 1970.

Family Medicine Education in Mississippi

R. E. SMITH, M.D.,* H. T. MILHORN, JR., M.D., Ph.D. and W. R. GILLIS, M.D.
Jackson, Mississippi

A FAMILY PHYSICIAN is one who: "(1) Serves as a physician of first contact with a patient by means of entry into the health care system; (2) evaluates the patient's total health needs, provides personal medical care within one or more fields of medicine, and refers the patient when indicated to the appropriate sources of care while preserving the continuity of his care; (3) assumes responsibility for the patient's comprehensive and continuous health care and acts as leader or coordinator of a team that provides health services; (4) accepts responsibility for the patient's total health care within the context of his environment, including the community and the family or comparable social unit."¹

This quote from the Willard Report, which was published in 1966, formally defines the specialty of family practice. The Willard report also sets forth a description of objectives of a curriculum for a graduate education program in family medicine. This report was brought about by several major factors. First, there was a rapid scientific and clinical advance in the era following World War II. Second, there had been a general decline in numbers of general practitioners from approximately 122,000 in 1931 (82% of all physicians) to approximately 71,000 in 1974, which made up only 18% of all physicians. At the same time the population had grown by 60%. The third factor was the lack of residency programs in general practice. It was against this background that the American Academy of General Practice was founded in 1947. The American Academy of General Practice became the American Academy of Family Practice in 1972.

The public did not particularly care whether the doctor they saw was called a family practitioner or a general practitioner; however, there often was a good deal of difference. The general practitioner usually provided only episodic care and had little training in preventive medicine or psychological

aspects of illness. Family physicians were to be trained to provide continuing, comprehensive care within the context of the family unit and to receive special background in the behavioral sciences. Preventive medicine was to be the forte of these physicians. In short, they were to be taught during residency training what many general practitioners had to learn by years of experience.

In 1969 family practice was designated as medicine's 20th specialty, a recognition by the community of the fact that a physician can be a specialist in breadth as well as depth. As of June, 1981 there were 386 approved family practice residencies in the United States in medical centers or in community hospitals, an increase from 49 in 1970.²

The Department of Family Medicine was created at the University of Mississippi Medical Center in 1973. Family medicine, as a specialty, at that time was only three years old. The program was established as a three year residency, with Dr. W. R. Gillis as chairman. The first four graduates of this program completed the residency in 1976. As of June 1981, 45 residents had completed the residency. Of these, 38 are now practicing in the state of Mississippi. Presently there are 34 Family Medicine Residents in training. The Department of Family Medicine now has 15 full time faculty, including a pediatrician, an obstetrician/gynecologist, a Ph.D. educator, and a psychologist. There are 19 part-time faculty in the program and a support staff of 39 people. In addition, 123 family physicians who serve as preceptors for medical students have clinical instructor status.

The Residency Program

The residency program consists of three years of graduate training (see Figure 1). The first year is essentially a rotating internship with three months of OB/GYN, three months of medicine which consists of two months at the Veterans Administration Hospital in Jackson and one month at Mississippi State Hospital at Whitfield, three months of pediatrics

From the Department of Family Medicine, University of Mississippi Medical Center, Jackson, MS.

* Dr. Smith died in February of this year.

RESIDENT SCHEDULE

MONTHS

FIRST YEAR RESIDENTS

INTERNAL MEDICINE	OBSTETRICS	PEDIATRICS	EMERGENCY ROOM	SURG- ERY
FAMILY PRACTICE CENTER - 1/2 DAY/WEEK				

SECOND YEAR RESIDENTS

PULMO- NARY BLOCK **	FAMILY PRACTICE CENTER - 4 HALF-DAYS/WEEK ASSIGNED ENRICHMENT * 3 FULL DAYS/WEEK			RURAL HIGH VOLUME BLOCK **
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THIRD YEAR RESIDENTS

TRAUMA BLOCK **	FAMILY PRACTICE CENTER - 4 HALF-DAYS/WEEK ASSIGNED ENRICHMENT * 3 FULL DAYS/WEEK			ELEC- TIVE BLOCK **
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* ENRICHMENT—ONE-MONTH EXPERIENCE IN A SPECIALTY OR SUB-SPECIALTY AREA HIGHLY RELEVANT TO THE PRACTICE OF FAMILY MEDICINE
11 REQUIRED, 15 SELECTED

**BLOCK—ONE-MONTH CONCENTRATED EXPERIENCE, RELIEVING RESIDENT OF COMMITMENT TO TIME IN FAMILY PRACTICE CENTER

Figure 1. Family Medicine Resident Schedule.

including one month of in-patient care, one month of out-patient care and one month of neonatology, two months of emergency room at the University Hospital, and one month of general surgery with a private surgical group in Jackson. During nine months of this first year the resident is in the family practice center one-half day a week. During this time he is assigned 25 families in the family practice center for which he has primary responsibility. The family practice center is a model clinic in which the residents practice as they would in a group family practice setting. There are two family practice centers, one in North Jackson (McWillie Family Medical Center) and one in South Jackson (West Jackson Family Medical Center, formerly Candlestick Family Medical Center). Patients from the centers are admitted to community hospitals. McWillie residents admit to Mississippi Baptist Medical Center and St. Dominic's Hospital and the South Jackson residents admit Hinds General Hospital.

The second year course curriculum is composed mainly of mandatory enrichments with two months open for selective enrichments. The term "enrichment" is used for any concentrated experience in a sharply defined, usually narrow, aspect of the overall teaching objective. Enrichments usually last for

one month but can be somewhat longer or shorter as indicated. During the second year there is also one month of rural high volume medicine, and one month for lecture series which includes such topics as electrocardiography, ophthalmology, psychological medicine, and prospective medicine. The required enrichments designated as second year ones are ENT, cardiology, gynecology, pulmonary, laboratory medicine, rheumatology, pediatrics, and orthopedics. The resident is out of the clinic system during his months on pulmonary and rural high volume medicine. Otherwise the resident sees patients in the Family Practice Center four half-days a week. The third year core context is mostly open for selective enrichments with only gastroenterology, neurology, practice management, and an emergency room (trauma) block required. Again, during the third year the resident is in the Family Practice Center four half-days a week. The resident is out of the clinic system during the emergency room (trauma) block which is done at Singing River Hospital in Pascagoula. Each of the enrichments is structured with a specific set of objectives and reading list.

The enrichment program is still developing and enlarging. At present it consists of approximately 40 different enrichments. Selective enrichments in-

clude adolescent medicine, allergy, geriatric medicine, hematology, nephrology, obstetrics, oncology, plastic surgery, psychiatry, psychological medicine, radiology, rheumatology, urology, primary care research, and infectious disease. The enrichment program makes available to the resident a wide range of experience and consultant expertise. Second and third year residents take call for their respective clinics approximately one night a week and one weekend a month.

The Department of Family Medicine is presently producing approximately 12 new family physicians a year. The state has recently been approved for a second family practice residency site in Gulfport. A residency training site is also under study for Tupelo.

Undergraduate Programs

Undergraduate family medicine programs in the University of Mississippi School of Medicine curriculum consist of: (1) a tutorial role in the sophomore year; (2) various lectures in the freshman and sophomore years; (3) a required junior preceptorship; (4) an elective senior clerkship; (5) a senior elective preceptorship.

During the freshman and sophomore years the faculty of the Department of Family Medicine presents conferences which consist of presentation of clinical material in coordination with the basic sciences. In the sophomore year the faculty and residents of the Department of Family Medicine assume a tutorial role in the Introduction to Clinic Medicine course. This is part of the curriculum dealing with history taking, physical diagnosis, and a large core of clinical content. Tutors help the students with history and physical examination skills and also contribute to the student's clinical knowledge base. Each family medicine tutor accounted for approximately 30 contact hours per student for 59 of the class of 150 students last year.

A three-week required junior preceptorship was included in the medical school curriculum in 1976. An additional elective week is also available. This rotation was structured to teach undergraduate students the concepts of practice in continuous and comprehensive family centered health care. The preceptorship begins with a two day orientation period followed by a three to four week preceptorship experience, then a one day debriefing period. A reading list is provided and a comprehensive examination is given at the end of the block. The junior preceptorship program has several objectives: (1) to learn and employ some of the essential dynamics of the doctor-patient relationship, (2) to reinforce and

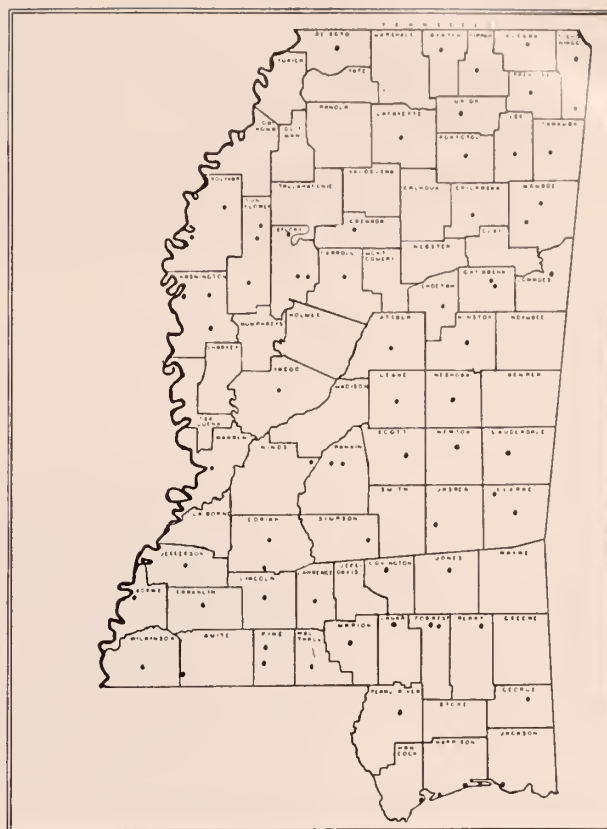


Figure 2. Family Medicine Preceptorship Sites.

refine techniques of history taking and physical examination, (3) to learn the most common and prevalent illnesses seen in family physicians' offices, (4) to emphasize preventive medicine, (5) to learn the function and need of a health care team in patient management, (6) to learn some economics of health care delivery, (7) to use selective portions of the problem oriented medical record in record-keeping in everyday practice, and (8) to recognize changes related to age which mean special responses to the elderly patient. A reading list is provided which contains articles that complement the objectives of the rotation.

The senior elective preceptorship is designed to increase the student's first hand knowledge of clinical, administrative, and social aspects of family medicine. It is four weeks in length. Each year approximately 50 students elect to take this course. The objectives of the senior preceptorship are: (1) to actively participate in patient care, (2) to practice

commonly used office laboratory procedures, (3) to improve skills in effective communication, (4) to develop and improve skills in selected procedures, (5) to extend the degree of preventive medicine practiced and concomitantly uncover asymptomatic problems, (6) to improve the recording phase of problem solving by using problem and management list, (7) to learn more of practice management, (8) to assess the community health care status, and (9) to improve skills in taking a family history (the genogram). The senior clerkship is essentially the same as the preceptorship except the site is in Jackson as the model practice centers. Faculty and residents serve as preceptors.

Junior and senior preceptorship programs are dependent on 123 family physician preceptors scattered over Mississippi for the practice sites (see Figure 2). The Department of Family Medicine holds annual workshops in various parts of the state which these preceptors must attend. The purpose of these workshops is to discuss new changes in objectives, discuss teaching strategies and, in general, help each preceptor to better understand his role and how to most effectively fill it.

Continuing Medical Education

One of the most important elements of the American Academy of Family Practice is the emphasis on continuing education. The Department of Family

Medicine provides a Continuing Medical Education Day in June each year for all family physician preceptors, and each fall the Department sponsors a three day Family Practice Update for all family physicians. The hours of Continuing Medical Education may be applied to the American Academy of Family Practice's requirement of 150 hours of continuing medical education every three years for maintenance of membership. These programs also help family physicians prepare for the recertification exam which is required every six years by the American Board of Family Practice.

In summary the Department of Family Medicine has made great strides in the past eight years. This is evidenced by the fact that 37 of the 150 graduating medical students this year chose a family medicine residency. It is hoped that the Department of Family Medicine will continue to serve the physicians of the state in their continuing education, and play an even greater role in the training of medical students.

★★★

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References

1. Report of the Ad Hoc Committee on Education for Family Practice of the Council on Medical Education. American Medical Association, 1966.
2. Proceedings of the FHFA Conference on Primary Health Care, May 14-16. Family Health Foundation of America, 1976.

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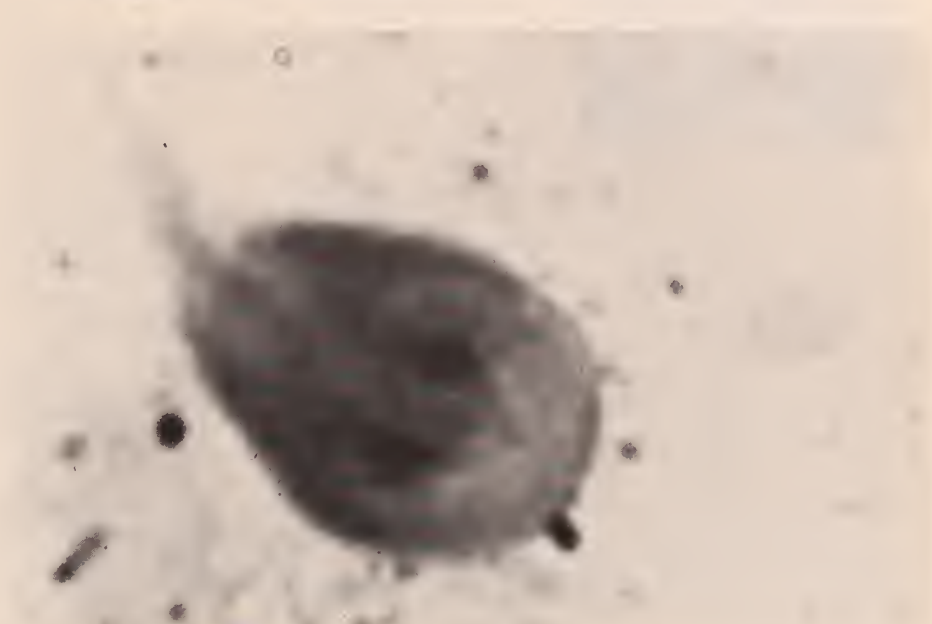
Those parasites that live primarily in the duodenum or bile ducts often are more readily seen in the duodenal contents than in the stool. These include *Giardia lamblia* (motile trophozoites), *Strongyloides stercoralis* (larvae and/or eggs in advanced stages of development), *Clonorchis sinensis* (eggs), *Fasciola hepatica* (eggs), *Trichostrongylus orientalis* (eggs), and *Isospora* (coccidia).

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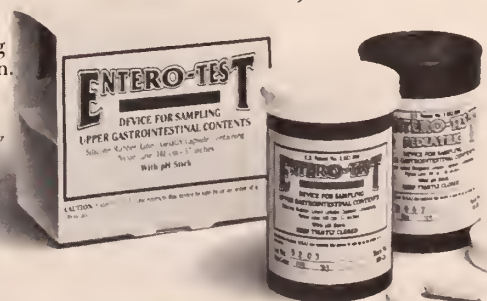
REFERENCES

1. Babb, R.R., Beal, C.B., Use of a Duodenal Capsule for Localization of Upper Gastrointestinal Hemorrhage, GUT 15:492, 1974.
2. Beal, C.B., et al., A New Technique for Sampling Duodenal Contents, Am. J. Trop. Med. & Hyg. 19:349, 1970.
3. Bezjak, B., Evaluation of a New Technique for Sampling Duodenal Contents in Parasitologic Diagnosis, Am J Dig Dis 17:845, 1972.
4. Mahmoud, AAF., Warren, KS., Algorithms in the Diagnosis and Management of Exotic Diseases II. Giardiasis, J. Infect. Dis. 131:621, 1975.
5. Thomas, GE., et al: Use of the Entero-Test Duodenal Capsule in the Diagnosis of Giardiasis, S. Afr. Med. J. 48:2219, 1974.
6. Kuberski, T.T., et al: Disseminated Strongyloidiasis, West. J. Med. 122:504, 1975.
7. Gilman, R.N., Hornick, RB: Duodenal Isolation of Salmonella typhi by String Capsule in Acute Typhoid Fever, J. Clin. Microbiol. 3:456, 1976.
8. Benavente, L., Gotuzzo, E., Guerra, J., et al: Diagnosis of Salmonella typhi by culture of duodenal string capsule, N. Engl. J. Med. 304:54, 1981.
9. Colon, AR: Sampling of Duodenal Contents by a Nylon Line, J. of Peds., 89:513, 1976.
10. Gracey, M., Suharjono, Sunoto: Use of a Simple Duodenal Capsule to Study Upper Intestinal Microflora, Arch. Dis. Child 52:74, 1977.
11. Baron J.H: The clinical use of gastric function tests, Scand. J. Gastroent. Suppl. 6:9, 1970.
12. Rosenthal, P., Liebman, W.M: Comparative Study of Stool Examinations, Duodenal Aspiration, and Pediatric Entero-Test for Giardiasis in Children, J. Pediatr. 96:278, 1980.
13. Liebman, W.M., Rosenthal, P: The string test for gastroesophageal reflux, Am. J. Dis. Child 134:775, 1980.



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The President Speaking

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R. FASER TRIPLETT
Jackson, Mississippi

As I have traveled throughout our state this year visiting and speaking to our component medical societies, my emphasis has been on involvement. Those of you who heard me, I hope, recall that I spoke directly to our being involved in three basic areas: the community; the affairs of organized medicine; and the political process.

Quite frankly and honestly I must admit my disappointment in at least two of these areas. I cannot speak with authority as to physician involvement in the community, but if you believe public opinion polls, we have lost some stature in our community involvement as perceived by the public.

In the area of organized medicine, MSMA membership looks good when we consider that over 85% of the practicing physicians in Mississippi belong to the association. But some 25% of our MSMA members don't belong to the AMA, which means that 40% of the practicing physicians in Mississippi are not members of AMA. Furthermore, it appears to me that many of our MSMA members are dues payors only and do not actively participate at any level of organized medicine insofar as contributing their time, effort, or ideas to the activities of organized medicine.

Then there is the area of our participation in the political process. Because of a very vigorous campaign this year by our Mississippi Medical Political Action Committee (MMPAC), total contributions in dollars to MMPAC has increased considerably. Looking at the roll of those who comprise this total, however, one is struck by the fact that it is basically the same people who have contributed before, contributing more. Approximately 40% of our MSMA members are contributing to MMPAC and carrying the load for the other 65% of physicians who are members of MSMA as well as the 15% of practicing physicians who are not members of MSMA. However, the benefits from the efforts and contributions of these MMPAC participants accrue to all Mississippi physicians equally.

As my year as your president comes to a close, let me thank you sincerely for the privilege to serve, for the gracious way you accepted Jackie and me into your communities and homes, and for the cooperation and assistance of every physician, auxiliary member and staff who contributed their efforts to the many programs and activities of our association this year.

My final thought was better said by Theodore Roosevelt. "Every man owes part of his time and money to the business or industry in which he is engaged. No man has a moral right to withhold his support from an organization that is striving to improve conditions within his sphere." Heed his advice and make your resolve today to be involved to a greater degree in *your* professional organization from this day hence. ★★

EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XXIII, Number 5

MAY 1982

To Die With Dignity

So often patients suffering from terminal illness are subjected to over-enthusiastic intensive care. The physician, in an effort to keep the patient alive, uses all the modern methods at his command. Glucose, transfusions, oxygen, respiratory therapy, blood gases and laboratory tests are ordered in profusion. Meanwhile, expenses pile up and the anxious family suffers to complete exhaustion.

Certainly, as long as there is a chance of restoring an acceptable *quality* of life, every effort should be made for recovery; but when the point of no return is reached, the physician, the family, and even the conscious patient will agree that heroic measures are no longer necessary or desirable.

Every effort should be expended to offer emotional support and obtain relief of pain and discomfort but futile procedures should be stopped.

As one patient recently told me, "Doctor, please remove all these damned tubes and needles, give me something for pain, and at least let me die with dignity."

GEORGE H. MARTIN, M.D.
Associate Editor

Medico-Legal Brief

MD Convicted of Helping Paramedic Practice Medicine Without License

A physician was properly convicted of aiding and abetting his licensed paramedic to practice medicine without a license, a District of Columbia appellate court ruled.

The paramedic, who worked at the physician's clinic, testified against the physician under a grant of immunity from the government. He testified that the physician came to the clinic once a week or once

every two weeks and that about 200 patients were treated at the clinic between July and November 1977. The physician performed the initial examinations of 10 to 20 patients, and he never saw 50 to 60 patients. The physician authorized the paramedic to give prescriptions when he was not present in the clinic and gave him a pad of 50 pre-signed prescriptions. The paramedic wrote approximately 75 to 80 prescriptions during that time; 25 percent were written after consulting with the physician by phone or in person. Some of those prescriptions were for controlled drugs.

Affirming the physician's conviction, the appellate court said that the paramedic was engaged in the diagnosis and treatment of illnesses. Two certified physician's assistants testified to the accepted uses of paramedics. They agreed that accepted practice required the physician to approve each prescription before it was issued and to review the patient's charts within 24 to 72 hours. The court said that the evidence supported a finding that the physician's actions grossly violated a policy statement by the Licensure Commission on the approved use of physician's assistants. The physician was put on notice that his manner of operation did not constitute an accepted use of a paramedic by the custom and usage of the medical profession and its policies and regulations, the court said.

The conviction was affirmed and the case remanded for sentencing. — *Jacobs v. U. S.*, 436 A.2d 1286 (D.C.Ct. of App., Oct. 29, 1981)



Counsel to Authors

THE JOURNAL welcomes manuscripts which should be submitted to the Editors at 735 Riverside Drive, Jackson, MS 39216, in original and at least one duplicate copy. They must be typewritten double spaced on 8½ by 11-inch white paper. **Brief manuscripts (about 2,500 words or 8 pages) will be given preference over longer articles.**

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WARNINGS: The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS: Although there are no absolute contraindications to pentylentetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of Ru-Vert who have heart disease. While pentylentetrazol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

Pheniramine maleate, like other antihistamines, may produce sedative side effects in certain patients.

Transient vasodilatation due to rapid absorption of nicotinic acid may produce facial flushing and a sensation of warmth. These effects may be ameliorated by recommending that Ru-Vert be taken following meals or with food.

ADVERSE REACTIONS: Pentylentetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylentetrazol.

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MEDICAL ORGANIZATION

Rising Costs May Produce Legislative Restraints

Health care providers could face legislatively imposed restraints if they fail to hold the line on medical costs. That was a warning issued by Rep. G. V. (Sonny) Montgomery at the MSMA's recent leadership conference in Jackson.

Montgomery commended the efforts of the AMA's Voluntary Effort (VE) to control costs, but noted that in 1981 the rate of spending for medical services in the United States grew by as much as 12.5 percent, compared to the overall inflation rate of 8.9 percent.

He called for a "more concerted and cooperative program by doctors, hospitals and suppliers of medical supplies and equipment," to slow the growth in health care costs without affecting the delivery of medical care to our fellow Americans, especially the elderly.

"While I am philosophically opposed to government price controls . . . I sense a growing concern in the Congress over the unusually large increases in health care costs," Montgomery said. "This concern could translate into some type of cost-containment legislation."

He pledged to reduce burdensome federal regulations, which he said had contributed to rising costs.

"The government is certainly not without blame and must do its part to lessen the regulatory and paperwork burden that contributes to cost increase," he said.



Dr. Whitman B. Johnson, chairman of the MSMA Board of Trustees, talks with U.S. Congressman G. V. (Sonny) Montgomery during the MSMA leadership conference in Jackson in March.

Conference Speakers Examine Medical Scene Issues

Third party payors are taking steps to hold down costs, and they need the continuing cooperation of health care providers, according to three panelists at the MSMA's first leadership conference, held recently in Jackson. Other panel speakers discussed more issues affecting the medical profession, such as malpractice, federal-state programs, and health legislation.

"Third Party Programs: Current Trends and Future Directions" was the topic discussed by Chandler Mosley, president of Blue Cross and Blue Shield, Bill Simmons, director of the Mississippi Medicaid Commission, and Gerald Godfrey, manager of Traveler's Medicare. All three described successful efforts to cut the programs' administrative costs and outlined future plans.

One such plan is Blue Cross-Blue Shield's new Cost Awareness Program (CAP), which calls for higher deductibles, variable deductibles and multiple deductibles. Mosley said the CAP plans have built-in incentives for less costly care, such as 80 percent coverage for outpatient care versus 70 percent coverage for inpatient care.

James Drake, director of congressional relations for the American Medical Association, outlined medicine's position on health legislation, and Dr.

(Continued on page 151)



Dr. R. Faser Triplett, MSMA president, introduces speakers at the association's leadership conference. Panelists are, left to right, James A. Drake, director of congressional relations for the AMA; Bill Simmons, director of the Mississippi Medicaid Commission; and Gerald Godfrey, manager of Traveler's Medicare.

Dr. Lamar Weems Elected To Urological Association Post

W. Lamar Weems, M.D., of Jackson was elected to the position of president-elect of the Southeastern Section of the American Urological Association at its 46th annual meeting in New Orleans, March 28-April 1.

Dr. Weems, professor of surgery and director of the Division of Urology at the University of Mississippi Medical Center, is currently serving as delegate to the American Medical Association for the Mississippi State Medical Association.

He is a native of Jackson, Mississippi and a graduate of Millsaps College and the Baylor College of Medicine. He completed his training in urology at the University of



Mississippi and the Massachusetts General Hospital in Boston. He has been on the faculty of the University Medical Center since 1965, and has been director of the Division of Urology since 1968. He is also chief of urology at the Jackson VA Hospital.

Dr. Weems is a fellow of the American College of Surgeons and holds membership in the American Urological Association, American Association of University Urologists, American Trauma Society, Mississippi Urological Society, the Society of Pelvic Surgeons and Southern Medical Association.

In 1981 the Mississippi State Medical Association presented Dr. Weems with the MSMA/Robins Award for Community Service in recognition of his many contributions to the education of deaf citizens of Mississippi and for his participation and service in other community and civic activities.

Dr. Weems recently completed three years as secretary of the Southeastern Section of the American Urological Association, representing over 1100 members from Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee and Puerto Rico. He will be inaugurated as president at the Southeastern Section's 47th annual meeting in Haines City, Florida, next March.

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Respiratory Therapy Board Honors Dr. Roy Wilson

Dr. Roy Wilson, chairman of the Department of Anesthesiology at the University of Mississippi Medical Center, has received an award of appreciation from the board of trustees of the National Board of Respiratory Therapy.

Dr. Wilson served on the board for 11 years, and at his retirement had served longer than any physician on the 24-member panel.

The award citation, presented at a recent meeting of the board, expressed "deep appreciation . . . for contributions and many years of service to the respiratory therapy profession. Your leadership and insight, your dedication and support of the credentialing system as a representative of the American Society of Anesthesiologists will be long remembered."

Dr. Wilson was professor of anesthesiology at Baylor College of Medicine in Houston, Texas, prior to accepting the Medical Center chair in 1977.

He is the author of more than 100 scientific papers.

Guest Lecturer at UMC



Dr. Walter M. Kirkendall, right, professor of medicine and director of the hypertension division at the University of Texas Medical School in Houston, presented medical grand rounds recently at the University of Mississippi Medical Center on "New Horizons in Beta Blocker Therapy." With him are, from left, Dr. Patrick Lehan, professor of medicine, Dr. Harper Hellems, Department of Medicine chairman, and Dr. Herbert Langford, professor of medicine.

Conference Speakers Examine Medical Scene Issues

(Continued from page 149)

James Manning, chairman of MSMA's political action committee (MPAC), stressed the importance of involvement by physicians.

The changing relationship in federal-state programs was discussed by James E. Cofer, director of the Commission of Budget and Accounting, Dick Molpus, director of the Governor's Office of Federal-State Programs, and Drs. Alton B. Cobb and C. Earl Fox, of the Mississippi State Board of Health.

Rounding out the program for the conference were a discussion of the University Medical Center by Dr. Norman C. Nelson, vice chancellor, and an update on medical malpractice by Dr. C. G. Sutherland, medical director of Mississippi Medical Fraternal and Educational Society (MMFES) and Bob Montgomery, general counsel for MMFES.

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AMA Loses FTC Appeal

The American Medical Association's seven-year battle against the Federal Trade Commission on the issue of physician advertising ended in a draw before the Supreme Court.

The 4-4 tie vote on the historic case leaves standing a lower court decision upholding the FTC.

The brief "per curiam" order, with Justice Harry Blackmun abstaining from the case, did little to settle the large legal questions raised in the AMA's appeal. Justice Blackmun did not participate, apparently because he had represented medical societies in the past.

As a consequence, the 1980 decision by the U.S. Court of Appeals in New York upholding the FTC's order against the AMA is left standing. The Supreme Court decision said simply: "The judgment is affirmed by an equally divided Court."

"The AMA is disappointed by the Supreme Court decision that failed definitively to resolve the important issues raised by the FTC's attempt to regulate the medical profession," said Joseph F. Boyle, M.D., AMA Board Chairman. "This has been a long drawn-out case stretching over seven years. The AMA had hoped that the Supreme Court would

decide the important issues itself. It may now be appropriate for Congress to consider the issues the Court failed to resolve and to clarify the law."

The AMA's appeal to the high court concerned an FTC order relating to the promulgation and enforcement of ethical guidelines in physician advertising and solicitation and physicians' contractual relationship with HMO's and group prepaid plans. A split decision by the U.S. Supreme Court means that no opinion is written, the names of the Justices who voted on either side are not disclosed, and the decision of the U.S. Court of Appeals for the Second Circuit (N.Y.) is allowed to stand.

Legislation has been introduced in the Congress that would redefine the FTC's authority. In the House, 170 representatives are co-sponsoring a bill (H.R. 3722) by Reps. Tom Luken (D-OH) and Gary Lee (R-NY) that would impose a moratorium on FTC actions against state-regulated professional associations or their state and national non-profit associations. A Senate measure (S. 1984) reauthorizing the FTC contains provisions exempting state-regulated professions from the scope of the FTC jurisdiction.

Thoracic Societies Meet in Biloxi



Mississippi Thoracic Society participants in the 26th Annual Tri-State Thoracic Case Conference, held recently in Biloxi, include Jacksonians Dr. James E. Griffith (left), Mississippi's program planning chairman, and Dr. Robert P. Henderson (right) president of the Mississippi Thoracic Society. They are pictured with Dr. Peter Armstrong, Professor of Radiology, University of Virginia School of Medicine, Charlottesville, Virginia, who served as consultant radiologist for the session. Twenty-one speakers from medical centers throughout the United States were featured at the two-day event sponsored by Lung Associations and Thoracic Societies of Mississippi, Louisiana and Alabama.

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AMA Urges New Course In Federal Programs

A basic restructuring of federal programs is required to solve the nation's health problems, the AMA has told Congress.

Calling for a "new course" setting priorities for the future rather than "quick-fix expediency," the AMA declined to take a position on the Administration's proposed budget cuts for Medicare.

"We believe that addressing individual items in particular programs does not provide the direction and leadership necessary to chart a course for the delivery of health care in this country for this and future decades," said Daniel Cloud, M.D., AMA President.

Accompanied by Fred Rainey, M.D., Chairman of the AMA's Council on Legislation, Dr. Cloud addressed both the House Ways and Means Health Subcommittee and the Senate Finance Committee on hearings concerned with Administration proposals to reduce Medicare/Medicaid expenditures.

Here are excerpts from the testimony of the two AMA spokesmen:

"... It is now time to step back from the pattern of looking at individual program budgets and attempt

to place in perspective the role of the federal government in financing and delivering medical services in the future. Now is the time to set priorities for the future and not continue to deal with crises on an annual basis."

Outlining to the lawmakers the sweeping new AMA policy, the spokesmen said the AMA intends to take the initiative to evaluate long-term health policies that will provide proper care for our citizens within the available national resources. "The AMA will hand down recommendations on both long-term and short-term health care problems."

"... There should be no sacred programs — a primary goal should be meeting the needs through governmental resources of those not able to provide for themselves.

"... The answers to our health problems are not to be found in arbitrary caps, in inequitable benefit reductions, in arbitrary cost shifting or in quick fix expediency — solutions will be found only when all interested parties participate in a basic restructuring of federal programs.

"... A first step might be to place health matters within a distinct Department of Health, both at the federal and state levels — health care is too important to be placed within a cabinet department that has

In 1977, when
the Veterans Administration
compared Step-2
regimens in 450 mild
hypertensive patients,
which regimen was
proven most effective?'



a major share of its activity devoted to welfare.

"... The AMA is committed to an economy characterized by strong, real growth and reaching this goal is necessary to ensure a quality living standard for everyone," the AMA witnesses said.

Some 20 health related and insurance organizations appeared before the House and Senate committees, each limited to a five-minute oral presentation. Most of the witnesses and a number of representatives and senators were hostile to the Administration's proposal for a flat two percent across-the-board cut in Medicare hospital reimbursement.

A limited edition, commemorative plate has been rendered for MSMA to recognize the association's 125th anniversary year and to finance construction of a "Country Doctor's Office" at the Mississippi Agricultural and Forestry Museum. Contact MSMA headquarters for information on purchasing your plate. Price is \$25.00.

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Surgical Forum Lecturers



Among guest lecturers for the University of Mississippi Medical Center's ninth annual surgical forum were, from left, Dr. William Curreri, professor of surgery and department chairman at the University of South Alabama; Dr. Alan Robert Dimick, associate professor of surgery and burn unit director, University of Alabama School of Medicine; and Dr. Donald D. Trunkey, professor of surgery and vice chairman of the department, University of California School of Medicine. Some 300 physicians representing 30 states attended the 1982 surgical forum sponsored by the UMC School of Medicine Department of Surgery and the Medical Center Division of Continuing Health Professional Education.

UMC Announces Faculty Appointments

Two assistant professors and an instructor have joined faculties at the University of Mississippi Medical Center in Jackson.

Dr. Robert Peter Yeziarski has been appointed an assistant professor of radiology. Dr. Jan Cornelis Roos has been appointed an instructor in medicine (research).

Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine Dean, announced their appointments following approval by the Board of Trustees, State Institutions of Higher Learning.

Dr. Yeziarski had been a postdoctoral fellow in the Marine Biomedical Institute at the University of Texas Medical Branch since 1981. He earned the B.A. and B.S. degrees at Virginia Polytechnic Institute and the Ph.D. at West Virginia University.

Dr. Young, co-director of the medical physics department at Mercy Hospital in Scranton, Pennsylvania, since 1980, earned the B.S. and M.S. degrees at the University of Kentucky.

Dr. Roos earned the M.D. at the State University of Utrecht in the Netherlands. Dr. Roos also took residency training in internal medicine and nephrology and held a fellowship in nephrology and hypertension at Utrecht.

POSTGRADUATE CALENDAR

May 22-23, 1982

NUCLEAR MEDICINE UPDATE

University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Radiology Division of Nuclear Medicine, the Medical Center Division of Continuing Health Professional Education and the Mississippi Society of Nuclear Medicine.

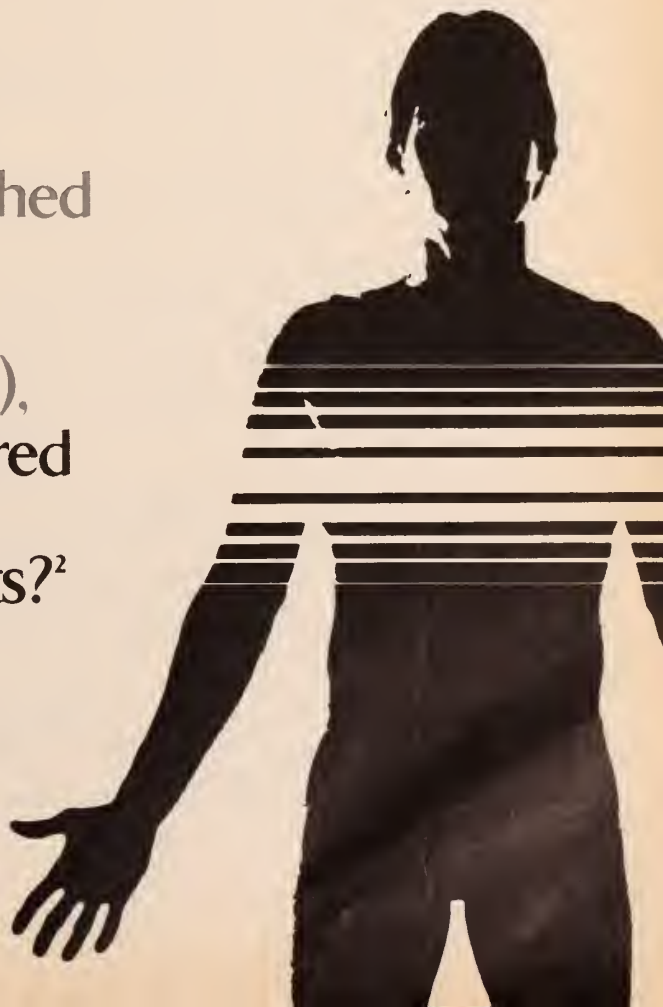
Coordinator: Jane Sanders, M.D., associate professor of radiology, University of Mississippi School of Medicine.

This program will focus on developments in clinical nuclear medicine imaging. Major emphasis is on newer techniques as well as established procedures. Fee: \$65 for Mississippi Society for Nuclear Medicine physician members; \$75 for nonmembers. Credit: 8 contact hours (.8 CEU), Category I of the AMA Physician's Recognition Award.

For more information on these programs, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone: (601) 987-4914.

Watch for Complete Report of 114th Annual Session
★ Coming in June *Journal MSMA* ★

In 1979, when results were published for the five-year, 10,000-patient Hypertension Detection and Follow-up Program (HDFP study), which Step-2 regimen was preferred and was deemed effective without significant adverse effects?²



MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 13-17, 1982, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

State and Local

Mississippi State Medical Association, 115th Annual Session May 11-15, 1983, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, June 30-July 3, 1982, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 3rd Wednesday, January, May, and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. J. Barry Gilbert, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December. Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Robert L. Coggin, Pres. and Secy., 965 Avenet Dr., Grenada 38901. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Pano-la, State, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March,

June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Albert H. Laws, Secy., 816 Second Ave. North, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, June, September, December. Robert D. Holbert, Secy., P.O. Box 1502, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Douglas F. Thomas, Secy., 415 South 28th Ave., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly
Mississippi State Medical Association
735 Riverside Drive
Jackson, MS 39216

North Mississippi Medical Center
830 Gloster Avenue
Tupelo, MS 38801

Forrest General Hospital
Box 1897
Hattiesburg, MS 39401

Mississippi Baptist Hospital
1225 N. State Street
Jackson, MS 39201

Gulf Coast Community/Gulfport
Memorial Hospital Consortium
4642 W. Beach Boulevard
Biloxi, MS 39531

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Delta Medical Center
Greenville, MS 38701

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Biloxi Regional Medical Center
1559 Lafayette St.
Biloxi, MS 39533

Mississippi Radiological Society
316 Medical Arts Building
Jackson, MS 39201

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

Mercy Regional Medical Center
100 McAuley Drive
Vicksburg, MS 39180

North Panola County Hospital
Drawer 160
Sardis, MS 38666

Singing River Hospital
2809 Denny Avenue
Pascagoula, MS 39567

Magnolia Hospital
Alcorn Drive
Corinth, MS 38834

Greenwood Leflore Hospital
1508 Leflore Avenue
Greenwood, MS 38930

South Washington County Hospital
Drawer 398
Hollandale, MS 38748

PERSONALS

S. LAMAR BAILEY of Kosciusko announces the association of JAMES W. BAILEY for the practice of general, thoracic and vascular surgery.

WILLIAM BATES of UMC was among program participants at a recent meeting of the Society for Gynecologic Investigation in Dallas, Texas.

JOHN R. BISE, III, of Jackson attended the recent meeting in New Orleans of the American Society for Colposcopy and Cervical Pathology, and was instructor in a laser course at the meeting.

H. REED CARROLL of Greenwood was recently named Leflore County's 1981 "Citizen of the Year" by the Greenwood Lions Club.

WALLACE CONERLY of UMC was a speaker at academic career week at the University of Mississippi recently and also spoke to the medical staff of Morehouse General Hospital in Bastrop, Louisiana.

C. M. DORROUGH of Ruleville has been recertified by the American Academy of Family Physicians.

EDGAR DRAPER of UMC recently spoke to members of the psychiatry service at the Veterans Administration Medical Center in Biloxi.

DAVID DUGGER has completed a year of sabbatical studies at the LSU Medical Center and has reopened his office for the practice of behavioral pediatrics and preventive medicine in Ocean Springs.

CLAUDE EARL FOX of Jackson was recently presented the 1981 Sidney S. Chipman Award for outstanding performance in the advancement of maternal and child health by the School of Public Health, University of North Carolina at Chapel Hill.

ALAN E. FREELAND of UMC was selected to associate membership in the American Society for Surgery of the Hand at its 37th Annual Meeting in New Orleans, and also presented a paper at the meeting.

GLEN GRAVES of UMC presented a paper at the annual Southern Society for Pediatric Research meeting in New Orleans.

RAYMOND F. GRENFELL, JR. of Jackson has been elected to fellowship in the American College of Physicians.

In 1980, when the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure published their recommendations, which Step-2 regimen best met their criteria for effectiveness, safety, simplicity of titration, convenience, and economy?³



JAMES HUGHES of UMC taught a workshop sponsored by the Southern Psychological Association in New Orleans.

WILLIAM LOCKWOOD of UMC presented a paper at the March meeting in Biloxi of the Mississippi and Louisiana Chapters of the American College of Physicians.

WILLIAM W. MAYERS announces the opening of his office for the practice of urology at Starkville Urology Clinic.

WILLIAM H. PRESTON of Booneville announces the limitation of his practice to gynecological surgery and office gynecology.

DAN R. THORNTON, III announces the opening of his office for obstetrics and gynecology at 1523-22nd Avenue in Meridian.

LAMAR WEEMS of UMC recently was visiting speaker at Duke University in Durham, North Carolina.

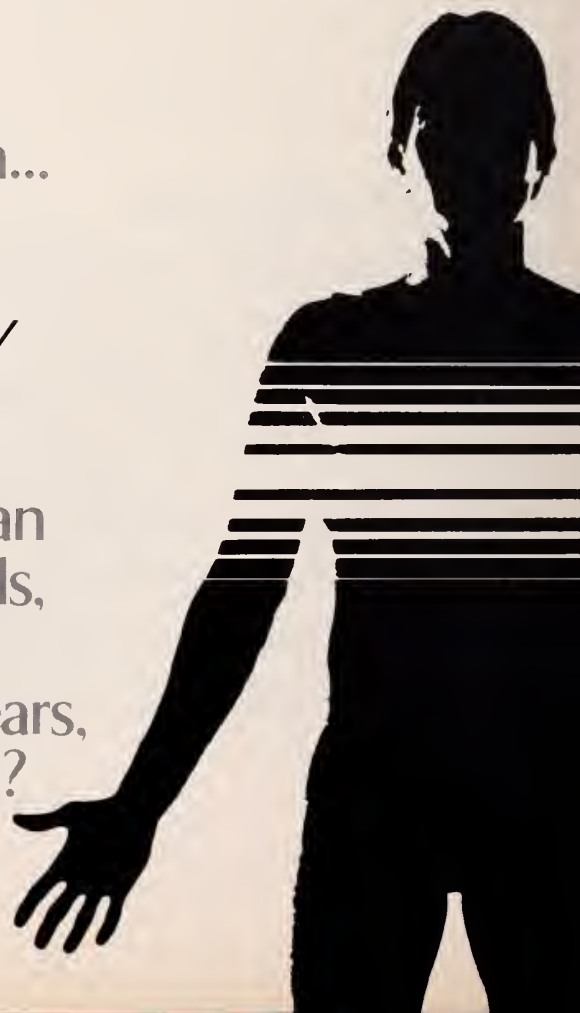
WINFRED WISER of UMC was a speaker at a symposium on advances in ambulatory obstetrics-gynecology in Lake Tahoe, California.



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NEW MEMBERS

BELL, RALPH B., Jackson. Born Kosciusko, MS, Oct. 26, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1970; interned University Medical Center, Jackson, one year; pathology residency, Tulane University, New Orleans, 1975-76; elected by Central Medical Society.

COOK, JOHN E., Pascagoula. Born St. Louis, MO, Dec. 28, 1951; M.D., Medical College of Wisconsin, Milwaukee, 1978; interned Milwaukee County General Hospital, one year; anesthesiology residency, Medical College of Wisconsin, 1979-81; elected by Singing River Medical Society.

DAVIS, MICHAEL L., Vicksburg. Born Wichita Falls, TX, June 16, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned University of Texas Health Science Center, San Antonio, one year; internal medicine residency, University Medical Center and V.A. Hospital, Jackson, 1979-81; elected by West Mississippi Medical Society.

FOOSE, R. MICHAEL, born Jackson, MS, June 24, 1943; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned Elizabeth Medical Center, Dayton, OH, one year; elected by Central Medical Society.

GRISSOM, CHARLES E., Jackson. Born Greenwood, MS, Jan. 11, 1943; M.D., University of Mississippi School of Medicine, Jackson, 1973; neurosurgery residency, University Medical Center, Jackson, one year; elected by Central Medical Society.

HUTCHINSON, NANCY K., Jackson. Born Baton Rouge, LA, Sept. 26, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned University Medical Center, Jackson, one year; elected by Central Medical Society.

MCDONALD, WILLIAM GLEN, Jackson. Born Ripley, MS, Nov. 22, 1945; M.D., University of Texas Southwestern Medical School, Dallas, 1978; interned and family practice residency, St. Paul Hospital, Dallas, 1978-81; elected by Central Medical Society.

And there's more proof on the way!

1982 will see the completion of the Multiple Risk Factor Intervention Trial (MRFIT)—a six-year, 12,000-patient study assessing the factors that increase risk of cardiovascular disease. For the management of hypertension, the preferred step-2 regimen in this study is reserpine-thiazide.

In 1978, in a preliminary report presented to the Epidemiology Section of the American Heart Association (Dallas, Nov 1978), after 12 months of the trial, fewer patients (5.3%) treated with reserpine suffered depression than even the untreated control group (7.7%)!

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PITRE, WAYNE MICHAEL, Vicksburg. Born Cut Off, LA, Feb. 19, 1951; M.D., Louisiana State University School of Medicine, New Orleans, 1976; interned Confederate Memorial Hospital, Shreveport, LA, one year; dermatology residency, Tulane, New Orleans, 1978-81; elected by West Mississippi Medical Society.

ROBERTS, BRUCE E., Jackson. Born Jackson, MS, Feb. 8, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned University Medical Center, Jackson, one year; elected by Central Medical Society.

SMITH, DEBORAH, Vicksburg. Born Haywood County, TN, Oct. 3, 1952; M.D., Vanderbilt University School of Medicine, Nashville, 1978; interned Vanderbilt Hospital, Nashville, one year; pediatrics residency, same, 1979-81; elected by the West Mississippi Medical Society.

STEPHENSON, WILLIAM L., JR., Jackson. Born Cleveland, MS, Oct. 19, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned John Sealy, University of Texas Medical Branch, Galveston, one year; anesthesiology residency, same, 1979-81; elected by Central Medical Society.

NOTICE

INTERNS, RESIDENTS, ANY PHYSICIAN LICENSED TO PRACTICE MEDICINE IN MISSISSIPPI

Positions for part-time medical consultants are now available at the Disability Determination Services of Mississippi. The pay and hours are good. Interns and residents wanting to interrupt their training programs for a year or more are welcome to apply. If interested, call 922-6811, ext. 2277 (Dr. John Barr) or ext. 2000 (Mr. John Cook).

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Use in Pregnancy

Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

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Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia

(especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

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Situations Wanted

HEMATOLOGIST-ONCOLOGIST seeks associate or solo practice. Contact Thomas Twele, M.D., 272 Shadow Mountain, El Paso, TX 79912.

SURGEON seeks location in general thoracic and cardiac surgery upon completion of residency in July, 1982. Graduate of Tulane University, 1975. Contact Dr. Kevin M. Keubler, 600 Highland Ave., Madison, WI 53792.

PHYSICIAN completing radiology residency in June 1982 seeks location with private community hospital. Graduate of Harvard. Contact Dr. Eugene B. Rosenberg, Mount Sinai Medical Center, 4300 Alton Road, Miami Beach, FL 33140.

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References:

1. Propranolol in the treatment of essential hypertension. Veterans Administration Cooperative Study Group on Antihypertensive Agents. *JAMA* 237:2303-2310, 1977.
2. Five-year findings of the hypertension detection and follow-up program: I. Reduction in mortality of persons with high blood pressure, including mild hypertension. Hypertension Detection and Follow-up Program Cooperative Group. *JAMA* 242:2562-2571, 1979.
3. The 1980 Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med* 140:1280-1285, 1980.

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PLACEMENT SERVICE / Continued

PHYSICIAN completing pathology residency in September 1982 seeks location with pathology group with emphasis on surgical pathology. Graduate of University of Tennessee School of Medicine. Contact Dr. William D. Crump, 1027-B Beacon Parkway East, Birmingham, AL 35209.

FAMILY PRACTICE resident seeks practice location in July 1983. Contact John D. Sites, M.D., 2002 Philip Dr., Muncie, IN 47302.

ANESTHESIOLOGIST seeks to relocate in state in solo, group or institutional practice. Contact M. T. Olivo, Jr., M.D., Box 794, Oxford, MS 38655.

GENERAL PRACTITIONER seeks practice location in small community. Contact Keith Hummell, M.D., 405 Mesaba Ave., Apt. 5C, Duluth, MN 55806.

OPHTHALMOLOGIST seeks practice location upon completion of military service in January 1982. Contact John R. Wood, M.D., 8430 Rocky Path, San Antonio, TX 78250.

BOARD ELIGIBLE INTERNIST seeks practice location; M.D. from University of Texas at Southwestern. Contact Stephen R. Cherry, M.D., 7061 B Creekview Trail, St. Louis, MO 63123.

BOARD ELIGIBLE PATHOLOGIST seeks practice opportunity. Graduate of University of Mississippi School of Medicine; residencies, UMC. Contact Marianna G. Pardue, M.D., 315 Cedarwood, Jackson, MS, 39212.

BOARD CERTIFIED FAMILY PRACTITIONER seeks practice location. Currently completing military obligation and available 7/82. Contact John E. Baites, Jr., M.D., 5405 Hackney Circle, Bossier City, LA 71111.

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JOURNAL MSMA encourages your participation. Comments, inquiries and suggestions are invited.

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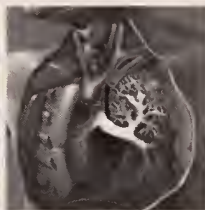
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in acute exacerbations of chronic bronchitis in adults...
clears the sputum and lowers its volume...on b.i.d. dosage

in shigellosis...
faster relief of diarrhea than with ampicillin²

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonia. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: General: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema

multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarthritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose[®] packages of 100; Prescription Paks of 20 and 28. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose[®] packages of 100; Prescription Paks of 40. Pediatric Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).



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in recurrent urinary tract infection

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Bactrim continues to demonstrate high clinical effectiveness in recurrent urinary tract infections. Bactrim reaches effective levels in urine, serum, and renal tissue¹...the trimethoprim component diffuses into vaginal secretions in bactericidal concentrations¹... and in the fecal flora, Bactrim effectively suppresses Enterobacteriaceae^{1,2} with little resulting emergence of resistant organisms.

1. Rubin RH, Swartz MN. *N Engl J Med* 303 426-432, Aug 21, 1980. 2. Data on file, Medical Department, Hoffmann-La Roche Inc.

BactrimTM DS

160 mg trimethoprim and 800 mg sulfamethoxazole

DOUBLE STRENGTH TABLETS

maximizes results with B.I.D. convenience



* due to susceptible strains of indicated organisms

Please see previous page for summary of product information.

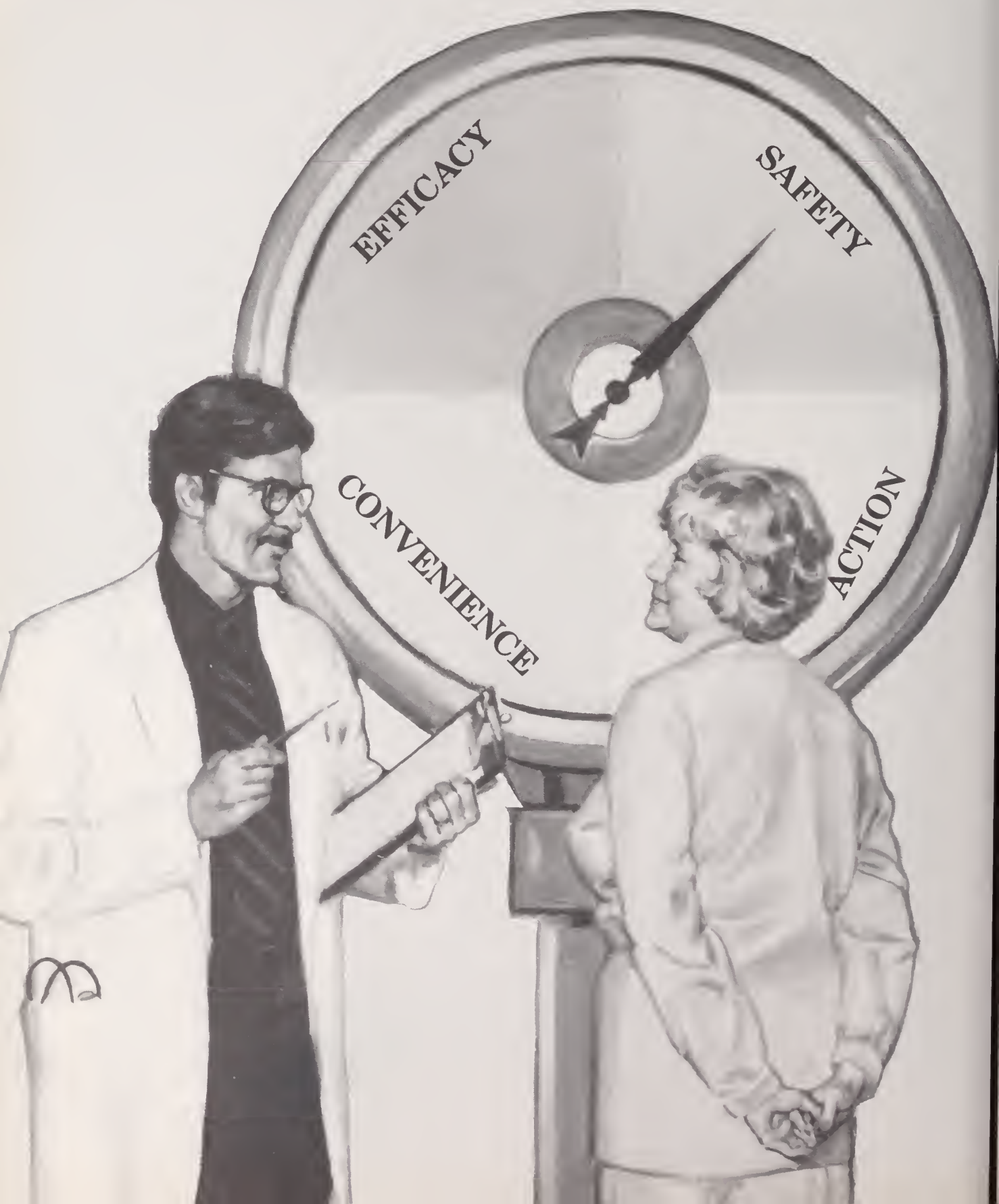
June 1982

JOURNAL of the **MISSISSIPPI** State Medical Association



Sidney O. Graves, Jr., M.D. — MSMA President, 1982-83

When your overweight patients seek your help with a weight reduction plan...



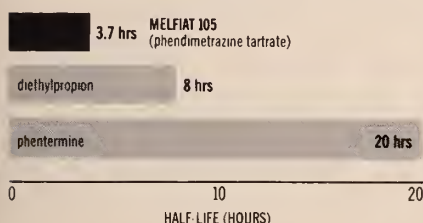
The benefits will outweigh the risks when you prescribe MELFIAT® 105

Because MELFIAT 105 effectively controls appetite. MELFIAT 105 (phendimetrazine tartrate), an effective anorexiant, provides the appetite control overweight patients often need to begin a successful program of weight reduction. And the positive results of initial short-term therapy with MELFIAT 105 can help motivate them to a lifelong commitment of weight control.

Because MELFIAT 105 has a 3.7 hour half-life and low abuse potential.

Therapeutic efficacy combined with a short half-life and minimal abuse potential make MELFIAT 105 the drug of choice in the treatment of exogenous obesity. Because MELFIAT 105 has a short half-life, it minimizes drug accumulation and helps to eliminate such effects as disturbed sleep patterns. And, because MELFIAT 105 has significantly lower abuse potential than the amphetamines,¹ there's less risk to your patients. According to a NIDA (National Institute on Drug Abuse) report, phendimetrazine appears to be the least abused anorexiant when compared to phentermine and diethylpropion:¹

Half-life comparison of MELFIAT 105 and other anorexiant²



Because MELFIAT 105 is in a sustained-release capsule.

MELFIAT 105 provides your patients with continuous drug delivery for appetite control that lasts throughout the day and helps to eliminate compulsive snacking and overeating at meals. In addition, the sustained-release capsule form maintains more constant blood levels of MELFIAT 105...without peaks and valleys.

Because MELFIAT 105 offers convenient, once-a-day dosage.

MELFIAT 105 is available in a convenient capsule containing 105 mg. The simple morning dosage regimen is designed to encourage compliance, minimizing the chance of missed doses and assuring optimum therapeutic results.

Because MELFIAT 105 is from Reid-Provident Laboratories, Inc.

Reid-Provident has the highest standards of quality to assure that only the finest products reach you. An advisory board of research scientists, physicians, pharmacists, and other technical staff continually review existing products and new product proposals to make sure that the latest pharmaceutical technology is used in their design and manufacture. That's because Reid-Provident is committed to you and your patients.

For more information please write to Reid-Provident Laboratories, Inc.
640 Tenth Street, N.W.
Atlanta, Georgia 30318

References: 1. Sheu YS, Ferguson JA, Cooper JR: *Evaluation of the Abuse Liability of Diethylpropion, Phendimetrazine, and Phentermine*, unclassified document ADAMHA, HHS, Office of Medical and Professional Affairs, NIDA, 1980. 2. Douglas JG, Munro JF: The role of drugs in the treatment of obesity, *Drugs* 21:362-373, 1981.

MELFIAT® 105 UNICELLES® III

(phendimetrazine tartrate)
Sustained-Release Capsules 105 mg

MELFIAT® 105 UNICELLES® III

(phendimetrazine tartrate) 105 mg Sustained-Release Capsules

INDICATIONS AND USAGE: Melfiat® 105 (phendimetrazine tartrate) is indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class (See CLINICAL PHARMACOLOGY) should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result).

WARNINGS: Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should be discontinued. Phendimetrazine tartrate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

Drug Dependence: Phendimetrazine tartrate is related chemically and pharmacologically to the amphetamines. Amphetamines and related stimulant drugs have been extensively abused, and the possibility of abuse of phendimetrazine tartrate should be kept in mind when evaluating the desirability of including a drug as part of a weight-reduction program. Abuse of amphetamines and related drugs may be associated with intense psychological dependence and severe social dysfunction. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high-dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG, manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia.

USAGE IN PREGNANCY: The safety of phendimetrazine tartrate in pregnancy and lactation has not been established. Therefore, phendimetrazine tartrate should not be taken by women who are or may become pregnant.

USAGE IN CHILDREN: Phendimetrazine tartrate is not recommended for use in children under 12 years of age.

PRECAUTION: Caution is to be exercised in prescribing phendimetrazine tartrate for patients with even mild hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of phendimetrazine tartrate and the concomitant dietary regimen. Phendimetrazine tartrate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure.

Central Nervous System: Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache; rarely psychotic episodes at recommended doses.

Gastrointestinal: Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances.

Allergic: Urticaria.

Endocrine: Impotence, changes in libido.

OVERDOSAGE: Manifestations of acute overdosage with phendimetrazine tartrate include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states.

Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma. Management of acute phendimetrazine tartrate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Acidification of the urine increases phendimetrazine tartrate excretion. Intravenous phentolamine (Regitine) has been suggested for possible acute, severe hypertension, if this complicates phendimetrazine tartrate overdosage.

DOSAGE AND ADMINISTRATION: Since Melfiat® 105 (phendimetrazine tartrate) 105 mg is a sustained-release dosage form, limit to one sustained-release capsule in the morning. Melfiat® 105 (phendimetrazine tartrate) is not recommended for use in children under 12 years of age.

HOW SUPPLIED: Each orange and clear sustained-release capsule contains 105 mg phendimetrazine tartrate in bottles of 100.

CAUTION: Federal law prohibits dispensing without prescription.



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*Please see following page for Brief Summary of Prescribing Information.



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BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

CONTRAINDICATIONS

INDERAL is contraindicated in: 1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL, 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

WARNINGS

CARDIAC FAILURE Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta-blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. INDERAL acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by INDERAL's negative inotropic effect. The effects of INDERAL and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during INDERAL therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, INDERAL therapy should be immediately withdrawn. b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS DURING ANESTHESIA with agents that require catecholamine release for maintenance of adequate cardiac function, beta blockade will impair the desired inotropic effect. Therefore, INDERAL should be titrated carefully when administered for arrhythmias occurring during anesthesia.

IN PATIENTS UNDERGOING MAJOR SURGERY beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, INDERAL should be withdrawn 48 hours prior to surgery, at which time all chemical and physiological effects are gone according to available evidence. However, in case of emergency surgery, since INDERAL is a competitive inhibitor of beta receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOLYCEMIA Because of its beta-adrenergic blocking activity, INDERAL may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY The safe use of INDERAL in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit.

Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of INDERAL may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura.

Central Nervous System lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to cataplexy, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium and decreased performance on neuropsychometrics.

Gastrointestinal nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory bronchospasm.

Hematologic agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Miscellaneous reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

ORAL

DOSEAGE AND ADMINISTRATION

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 40 mg INDERAL twice daily, whether used alone or added to a diuretic. Dosage may be increased gradually until adequate blood pressure is achieved. The usual dosage is 160 to 480 mg per day. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

While twice-daily dosing is effective and can maintain a reduction in blood pressure throughout the day, some patients, especially when lower doses are used, may experience a modest rise in blood pressure toward the end of the 12 hour dosing interval. This can be evaluated by measuring blood pressure near the end of the dosing interval to determine whether satisfactory control is being maintained throughout the day. If control is not adequate, a larger dose, or 3 times daily therapy may achieve better control.

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

INTRAVENOUS

The intravenous administration of INDERAL has not been evaluated adequately in the management of hypertensive emergencies.

OVERDOSAGE OR EXAGGERATED RESPONSE

IN THE EVENT OF OVERDOSAGE OR EXAGGERATED RESPONSE THE FOLLOWING MEASURES SHOULD BE EMPLOYED:

BRADYCARDIA ADMINISTER ATROPINE (0.25 to 1.0 mg). IF THERE IS NO RE-

SPONSE TO VAGAL BLOCKADE ADMINISTER ISOPROTERENOL CAUTIOUSLY.

CARDIAC FAILURE DIGITALIZATION AND DIURETICS.

HYPOTENSION—VASOPRESSORS, e.g., LEVATERENOL OR EPINEPHRINE (THERE IS EVIDENCE THAT EPINEPHRINE IS THE DRUG OF CHOICE).

BRONCHOSPASM ADMINISTER ISOPROTERENOL AND AMINOPHYLLINE.

HOW SUPPLIED

INDERAL (propranolol hydrochloride)

TABLETS
No. 461—Each scored tablet contains 10 mg of propranolol hydrochloride in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 462—Each scored tablet contains 20 mg of propranolol hydrochloride in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 464—Each scored tablet contains 40 mg of propranolol hydrochloride in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 468—Each scored tablet contains 80 mg of propranolol hydrochloride in bottles of 100 and 1,000. Also in unit dose package of 100.

INJECTABLE

No. 3265—Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10.

Reference: 1. Feis, E. D. Hypertension (Suppl. II) 3:230 (Nov.-Dec.) 1981.

7997/482

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NEWSLETTER

June 1982

Dear Doctor:

The Senate Commerce Committee has adopted an AMA-supported amendment to the Federal Trade Commission Amendment Act of 1982. The amendment would provide that the FTC does not have jurisdiction over state-regulated professions and their associations, and would prohibit FTC preemption of state laws governing the professions. The amendment passed by a vote of 10-5; the order to report the bill to the full Senate passed by 11-3.

Senator Cochran is among sponsors of the Senate bill. In the House, Congressman Trent Lott is sponsoring similar legislation, supported by Congressmen Bowen, Dowdy and Montgomery. Bipartisan supporters apparently agree the legislation would clarify an issue that was left unresolved by the Supreme Court's recent tie vote.

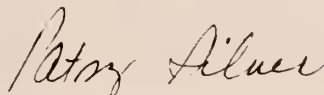
Six more health systems agencies (HSAs) are expected to close by Sept. 30, reports the federal Bureau of Health Planning. HHS terminated 27 agencies last fall after governors in five states exercised the option to consolidate health planning activities into single state agencies. About 60% of HSAs have been placed on conditional status for not meeting staffing requirements.

Hospital and doctors' charges for patients with smoker-related diseases are \$20.3 billion a year, says a Chicago Tribune columnist, who adds that under our system of third-party payment "all of us pick up their bill...Each American is paying \$174.65 a year in added insurance payments, doctors' fees and related costs because of smokers," he concludes.

Physicians' fees rose at a rate of 0.5% in March, less than the rate of increase for medical care index (0.8%) but greater than the all-items component (-0.1%) and all-services component (0.1%) of the CPI. Dentists' fees rose at a rate of 0.7% and hospital room charges went up 0.9% during the month. Prescription drug charges were up 1.3%.

Dr. Jim Manning, MMPAC chairman, accepted from Dr. Dan Cloud, AMA president, the first place AMPAC award for ratio of members to potential members during the recent 114th Annual Session in Biloxi. This issue of Journal MSMA includes information on that presentation and complete details of other annual session activities.

Sincerely,



Patsy Silver
Managing Editor

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DATELINE

Support MSMA Medical Exhibit Jackson, MS - MSMA members are urged to send tax-deductible donations to help construct a country doctor's office at the new Agricultural and Forestry Museum, a project endorsed by the Board of Trustees. Donors of \$25 will receive a limited edition, decorative plate commemorating MSMA's 125th anniversary year. Also, names of donors of \$100 will be inscribed on a plaque at the exhibit. You may call MSMA headquarters for information on sending your contribution.

Survey Identifies Family MD Concerns Chicago, IL - Time pressures, paperwork, perceived interference with the doctor/patient relationship, and financial costs involved in operating a medical practice are sources of dissatisfaction among many family physicians, according to a survey to be published in the Journal of Family Practice. The survey of residency-trained family physicians found that a large majority are satisfied with most aspects of their careers, however.

Cost Training For Physicians Washington, DC - Physicians need medical school training in providing medical care in the most cost-effective manner, says the General Accounting Office (GAO). A report has recommended that the Department of HHS incorporate such training at medical schools and on a carefully-selected basis provide federal funding for seminars and conferences on the issue. The GAO says medical school courses vary widely in approach and emphasis and need to be increased.

Politician's Health Ideas Criticized New York, NY - An American Council on Science and Health publication has harshly criticized the "unorthodox anti-scientific philosophy" of California Gov. Jerry Brown. The article deplores his appointment of 10 chiropractors to the state's medical quality assurance boards (which don't regulate chiropractors), his support of Laetrile, "inept handling of the Medfly problem," advocacy of raw milk and other "health foods," and espousment of "nutrition misinformation."

New Cabinet Post Proposed Chicago, IL - At its April meeting, the AMA Board of Trustees approved a draft bill to create a separate department of health at the federal level. The proposed cabinet-level department, headed by a physician, would administer all programs related to health now under the jurisdiction of HHS and would also establish a commission to coordinate and reduce duplicative and overlapping federal health programs.

Counsel to Authors

THE JOURNAL welcomes manuscripts which should be submitted to the Editors at 735 Riverside Drive, Jackson, MS 39216, in original and at least one duplicate copy. They must be typewritten double spaced on 8½ by 11-inch white paper. **Brief manuscripts (about 2,500 words or 8 pages) will be given preference over longer articles.**

The author is responsible for all statements made in his work, including changes made by the manuscript editor. Manuscripts are received with the understanding that they are not under simultaneous consideration by any other publication and have not been previously published. All manuscripts will be acknowledged, and while those rejected are generally returned to the author, the JOURNAL is not responsible in event of loss. Manuscripts accepted for publication become the property of the JOURNAL and are copyrighted by the association when published. They may not be published elsewhere without written release and permission from both the JOURNAL and the author.

All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus*, volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes

may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made.

Illustrations consist of all material which cannot be set into type such as photographs, line drawings, graphs, charts, and tracings. Illustrations should be submitted separately from text copy. Figures and drawings should be professionally prepared with black ink on white paper. Photographs should be of high resolution, unmounted, untrimmed, glossy prints. Each must be clearly identified. No charges are made to authors for up to four illustration engravings. More are not permitted unless voted on by two editors and extra costs must be absorbed by the author.

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In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material.

A thesis summary of 75 to 100 words must accompany each manuscript.

Reprints may be obtained at cost plus shipping charges from the association and **should be ordered prior to publication.** The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. — *The Editors.*

In addition, in view of *The Copyright Revision Act of 1976*, effective Jan. 1, 1978, transmittal letters to the editor should contain the following language: "In consideration of the Mississippi State Medical Association's taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the MSMA in the event that such work is published by the MSMA." We regret that transmittal letters not containing the foregoing language signed by *all* authors of the submission will necessitate delay in review of the manuscript. — *The Editors.*

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agitation
anorexia
feelings of guilt
and worthlessness
fatigue
palpitations
headache
vague aches
and pains
sadness
psychic and
somatic anxiety

Artist's conception,
looking out from the human eye
as conceived in a schematic model.



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Many patients respond readily to a single bedtime dose of Limbitrol, a convenient schedule that may enhance compliance and helps relieve the insomnia associated with anxious depression. Limbitrol also offers a choice of other regimens: t.i.d., or a divided dose with the larger portion h.s. In all cases, caution patients about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as driving or operating machinery.

in moderate depression and anxiety

Limbitrol® IV

Tablets 5-12.5 each containing 5 mg clordiazepoxide and 12.5 mg amitriptyline
(as the hydrochloride salt)

Tablets 10-25 each containing 10 mg clordiazepoxide and 25 mg amitriptyline
(as the hydrochloride salt)

Specific therapy with h.s. dosage convenience

Please see summary of complete product information on following page.

LIMBITROL® TABLETS Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use at this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation at either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias in the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays at 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks at 50.

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* Meeting of Am Soc Colon / Rectal Surgeons, May 1980.

** Based on total prescriptions filled for hemorrhoidal preparations during the first three quarters of 1981. The National Prescription Audit, IMS America Ltd, Sept 1981.

* 1981 data from leading marketing research organization.

PD-85-JA-0867-P-1 (2-82)

ANUSOL-HC[®] Suppositories/ ANUSOL-HC[®] Cream

Before prescribing, please see full prescribing information. A Brief Summary follows:

Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in external and internal hemorrhoids, proctitis, papillitis, cryptitis, and fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery. Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol[®] Suppositories or Ointment.

CONTRAINDICATIONS

Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

WARNINGS

The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

PRECAUTIONS

General

Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.

Pregnancy

See "WARNINGS"

Pediatric Use

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

DOSEAGE AND ADMINISTRATION

Anusol-HC Suppositories—Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

Store between 59°-86°F (15°-30°C)
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- No Radiation
- Outpatient and Inpatient Use

Studies have confirmed the following applications for the Entero-Test:

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Those parasites that live primarily in the duodenum or bile ducts often are more readily seen in the duodenal contents than in the stool. These include *Giardia lamblia* (motile trophozoites), *Strongyloides stercoralis* (larvae and/or eggs in advanced stages of development), *Clonorchis sinensis* (eggs), *Fasciola hepatica* (eggs), *Trichostrongylus orientalis* (eggs), and *Isospora* (coccidia).

SALMONELLA TYPHI:

Multiple stool exams cultured over several weeks or duodenal intubation are the most commonly used procedures. The Entero-Test is as efficient as intubation but simpler and more comfortable. New studies have further confirmed superior applicability over other procedures.

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Chronic Diarrhea caused by anaerobic and aerobic bacteria in infants and children was easily identified using the Entero-Test. The string test was comparable to or better than duodenal aspirate in all cases.



Giardia lamblia

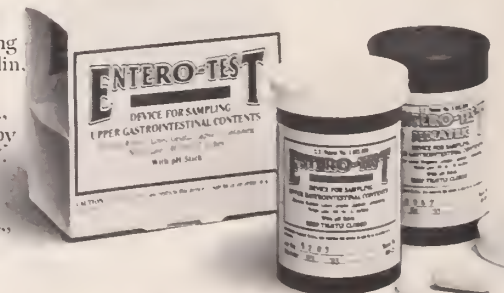
REFERENCES

1. Babb, R.R., Beal, C.B.: Use of a Duodenal Capsule for Localization of Upper Gastrointestinal Hemorrhage. *GUT* 15:492, 1974.
2. Beal, C.B., et al.: A New Technique for Sampling Duodenal Contents. *Am. J. Trop. Med. & Hyg.* 19:349, 1970.
3. Bezjak, B.: Evaluation of a New Technique for Sampling Duodenal Contents in Parasitologic Diagnosis. *Am. J. Dig. Dis* 17:845, 1972.
4. Mahmoud, A.A.F., Warren, K.S.: Algorithms in the Diagnosis and Management of Exotic Diseases II. *Giardiasis*. *J. Infect. Dis.* 131:621, 1975.
5. Thomas, G.E., et al.: Use of the Entero-Test Duodenal Capsule in the Diagnosis of Giardiasis. *S. Afr. Med. J.* 48:2219, 1974.
6. Kuberski, T.T., et al.: Disseminated Strongyloidiasis. *West. J. Med.* 122:504, 1975.
7. Gilman, R.N., Hornick, R.B.: Duodenal Isolation of *Salmonella typhi* by String Capsule in Acute Typhoid Fever. *J. Clin. Microbiol.* 3:456, 1976.
8. Benavente, L., Gotuzzo, E., Guerra, J., et al.: Diagnosis of *Salmonella typhi* by culture of duodenal string capsule. *N. Engl. J. Med.* 304:54, 1981.
9. Colon, A.R.: Sampling of Duodenal Contents by a Nylon Line. *J. of Peds.* 89:513, 1976.
10. Gracey, M., Suhajono, Sunoto: Use of a Simple Duodenal Capsule to Study Upper Intestinal Microflora. *Arch. Dis. Child* 52:74, 1977.
11. Baron, J.H.: The clinical use of gastric function tests. *Scand. J. Gastroent. Suppl.* 6:9, 1970.
12. Rosenthal, P., Liebman, W.M.: Comparative Study of Stool Examinations, Duodenal Aspiration, and Pediatric Entero-Test for Giardiasis in Children. *J. Pediatr.* 96:278, 1980.
13. Liebman, W.M., Rosenthal, P.: The string test for gastroesophageal reflux. *Am. J. Dis. Child* 134:775, 1980.



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**Obstetrics and Gynecology Grand Rounds:
Clinical Case Management III**

Management of Premature Rupture of Membranes

G. RODNEY MEEKS, M.D., Moderator

DR. MEEKS: D. M., a 37-year-old G5, P4 black female, was admitted to the delivery suite at approximately 31-32 weeks gestation by menstrual dates. She gave a history of ruptured membranes. She had been followed at a local prenatal clinic with no complications. Her past medical history was unremarkable. How does one manage this problem?

DR. CROMARTIE: The basic trilogy is the history, physical examination, and laboratory data. Between 7% and 12% of all pregnant women have rupture of membranes prior to the onset of labor. Most often the rupture occurs spontaneously for reasons which are unknown. Premature rupture does, however, increase with advancing maternal age, abdominal trauma, transverse lie, macrosomia and amnion infection. Usually rupture of membranes is painless and is heralded by a sudden gush of fluid which soils the woman's clothing. However, if fluid loss is not significant, the diagnosis may be difficult. The most

Panelists: A. Dean Cromartie, M.D., Hattiesburg, Mississippi; William H. Henderson, M.D., Oxford, Mississippi; Elbert M. "Sonny" Jones, M.D., Meridian, Mississippi.

common problem one has to separate from rupture of membranes is urinary incontinence. As pregnancy progresses, urination becomes more frequent, some degree of incontinence is common, and cystitis often worsens these symptoms. Less commonly, a woman with *Trichomonas vaginalis* infection will have a discharge which is heavy enough to soil her underclothes. Fortunately, symptoms of vaginitis (discharge, odor and irritation) are often present and help distinguish this diagnosis. One should also inquire about previous episodes of premature rupture of membranes (PROM) since these women are at risk during subsequent pregnancies. Since labor is common following PROM, one should ask about evidence of labor such as contractions, passage of mucus, backache, pelvic pressure, and an urge to

From The University of Mississippi Medical Center, Department of Obstetrics and Gynecology, 2500 North State Street, Jackson, MS.

OB-GYN GRAND ROUNDS / Continued

defecate or urinate. One should of course do a general history to rule out other problems.

DR. HENDERSON: One should first perform a general physical exam, then the obstetric exam. One should measure the fundal height and palpate the uterus to determine fetal lie and presentation. Keep in mind that the uterus may seem smaller following rupture of membranes with a significant loss of amniotic fluid. Next, one should perform a sterile speculum exam to visualize the cervix and estimate dilation and effacement. Fluid may be present in the vagina and can be collected for lecithin/sphingomyelin (L/S) ratio determination. If gross fluid is not present, one may apply pressure on the uterus or have the woman valsalva. If fluid still is not present, a nitrazine test and fern test on vaginal secretions may help to document rupture. Nitrazine paper is a pH paper which changes color in neutral or alkaline solution. Ordinarily the vagina is acidic and the yellow paper will not change color. If amniotic fluid (which is slightly basic) leaks into the vagina, the pH tends to be neutral or slightly basic which turns the paper blue. A false-positive nitrazine test can be seen with even small amounts of blood. The fern test relies on the formation of sodium crystals an arborized pattern when amniotic fluid is collected from the posterior vaginal fornix, placed on a slide and allowed to air dry.

DR. MEEKS: If the cervix appears to be open at the time of speculum exam or if amniotic fluid cannot be collected from the vagina, how does one proceed?

DR. CROMARTIE: Usually one is able to evaluate the cervix visually. Unless labor begins, I do no vaginal exams. However, if the patient appears to be dilated, I will examine her. If I am unable to collect free-flowing amniotic fluid vaginally, then certainly I would consider amniocentesis. The L/S ratio allows one to predict if the baby will develop respiratory distress syndrome (RDS).

DR. MEEKS: What laboratory data is important?

DR. JONES: I am mainly concerned about the white blood cell (WBC) count and differential. Normal pregnant women will have 10,000-12,000 WBC and normal differential. If the count were higher or a shift to the left were present, I would be more concerned. I would also order a urinalysis to rule out cystitis.

DR. MEEKS: How does one document gestational age?

DR. JONES: Her dates will alter my management considerably. Fortunately, most of my patients come

in early, and I am able to compare the early uterine size to last menstrual period, then continue to correlate size and dates. At 20 weeks the uterus is almost always at the level of the umbilicus. Also, I measure the fundal height as centimeters above the symphysis. Between 20 and 36 weeks gestation, centimeters correspond to weeks. Ordinarily, primigravida can document quickening at approximately 19 weeks and multigravida at 18 weeks. Fetal heart tones are audible by fetoscope at 20 weeks gestation. Should I not hear them, I have the patient return every two weeks until I do.

DR. MEEKS: Is sonography beneficial?

DR. CROMARTIE: Yes, but sonography may be incorrect by two weeks, especially late in pregnancy. Before amniocentesis I would certainly do sonography to document the presence or absence of fluid and the location of the placenta.

DR. MEEKS: This patient had eclamptic seizures during her first pregnancy. She required a low segment transverse cesarean section for transverse lie during her second pregnancy. Her third and fourth pregnancies terminated in uncomplicated vaginal deliveries. Her general physical exam was unremarkable. She had no fever. Her uterus measured S + 28 cm. Fetal heart tones were present and the uterus was neither tender nor irritable. The fetus was vertex presentation. A sterile speculum exam revealed no fluid, but the fern test was positive and the nitrazine paper turned deep blue. The biparietal diameter by sonogram was 7.9 cm which was consistent with 32 weeks. The placenta was located on the anterior uterine wall and very little amniotic fluid was identified. Her WBC was 11,500 and the differential was normal. Electronic fetal monitoring indicated the fetal heart rate (FHR) was approximately 160 with good variability and no decelerations. No contractions were noted. How does one proceed from here?

DR. HENDERSON: Remember one is managing two patients. The risk to the mother before delivery is chorioamnionitis. Following delivery she is very likely to develop myometritis, especially if she has a cesarean section. If she develops significant infection, she can usually be treated adequately with antibiotics, although her hospital stay ordinarily will be longer. However, some patients become quite ill, require prolonged antibiotic therapy and may even require surgery.

DR. JONES: The fetus is at risk for infection too. If a fetus is born with congenital infection, one can anticipate a very stormy course. Fortunately, even with chorioamnionitis fetal infection is unusual. However, the most serious problem for any preterm

infant continues to be immature lungs which may lead to RDS.

DR. HENDERSON: The mother should be at bedrest with bathroom privileges. One should evaluate uterine tenderness and irritability at least twice daily and more often if possible. Indeed, we have all seen those patients who are perfectly well one moment and extremely ill the next.

DR. JONES: The maternal pulse and FHR should be recorded at least every four hours since fetal and maternal tachycardia are often the first sign of infection. A WBC and differential should be checked every 12 hours. Although fever is often a late finding, the patient's temperature should be taken every four hours.

DR. CROMARTIE: Since amniotic fluid could not be collected for L/S ratio, one must use clinical judgement. If the fetus were 35 weeks or beyond, I would not hesitate to deliver. Even if the infant develops RDS, it ordinarily will be mild. I would be very hesitant to deliver an infant less than 32 weeks, even if the L/S were mature, because the infant would be at risk for a host of other problems including necrotizing enterocolitis, hyperbilirubinemia and infection — not to mention the expense involved in caring for this premature baby. Therapy must be individualized between 32 and 35 weeks. As long as no evidence of infection existed, I would follow the patient.

DR. HENDERSON: I would discharge the patient after three or four days if she had no evidence of labor or infection.

DR. JONES: I would evaluate the patient on a regular basis, repeat the WBC and check for uterine tenderness. I would also attempt to collect amniotic fluid for L/S ratio. Once there is evidence of infection, labor or fetal lung maturity, delivery is indicated.

DR. CROMARTIE: This discussion is predicated on the patient having a stable presentation, i.e. vertex or frank breech. If the presentation is unstable such as transverse lie, oblique lie or footling breech, the risk of prolapsed cord is greatly increased. Because of this increased risk to the fetus, I would deliver the patient.

DR. MEEKS: Is corticosteroid therapy indicated to mature the fetal lungs?

DR. JONES: No.

DR. CROMARTIE: I would consider using them under different circumstances, such as premature labor with intact membranes, but not in this patient.

DR. MEEKS: Are tocolytic agents indicated to stop premature labor?

DR. HENDERSON: I do use tocolytic agents but not

in a patient with ruptured membranes. Labor is often an event which suggests chorioamnionitis.

DR. JONES: I agree. If membranes are ruptured, labor is nature's way of saying the fetus should be delivered.

DR. MEEKS: She had no signs of labor or infection and continued to leak fluid, though none could be collected. After three days of observation, she was discharged. Three days following discharge she returned with lower abdominal pains. The uterus was tender and irritable. How should one manage this patient now?

DR. CROMARTIE: There comes a point when delivery is necessary even if it is not an optimal time for the baby. One needs to decide whether the patient can be delivered at the local hospital or if the patient should be referred to a tertiary center.

DR. JONES: I agree that the patient should now be delivered. If the fetus were 35 weeks or beyond, I would deliver her at my hospital because the pediatricians are comfortable caring for these babies. If the fetus were beyond 33 weeks and had a mature L/S, I would deliver the mother at my hospital if the pediatricians agree. However, if the fetus were less than 33 weeks, the patient should be referred because the baby will very likely need long-term complicated nursery care.

DR. HENDERSON: Sometimes the patient labors so quickly that there is no time for transfer. Under these circumstances, especially with an extremely premature baby or an immature L/S ratio, I would call the neonatal transport team. The baby can immediately be transferred to a tertiary neonatal center by an experienced team of pediatricians.

DR. JONES: The transport team from Jackson does an excellent job. They are available, quick and provide good care for the baby. The best transport, however, is in utero.

DR. MEEKS: Should this patient undergo repeat cesarean section?

DR. HENDERSON: The National Task Force on Cesarean Section has suggested that all patients have a trial of labor. However, at my hospital it is safer to perform a cesarean to minimize the risk of emergency complications such as ruptured uterus.

DR. CROMARTIE: If the mother were very close to vaginal delivery one could allow her to deliver. For any premature infant a saddle block should be utilized to achieve pelvic floor relaxation and to reduce pressure on the fetal head. Cutting a generous episiotomy and using forceps will also reduce the chance of fetal trauma. Following delivery one should manually explore the uterus for defects at the site of the old surgical scar.

OB-GYN GRAND ROUNDS / Continued

DR. MEEKS: The patient delivered following only two hours of labor. The female infant weighed 1400 grams, had Apgar scores 8/10, and was 32 weeks by Dubowitz Examination. Exploration of the uterus revealed an intact uterine scar. How does one manage this patient during the postpartum period?

DR. HENDERSON: Because of the potential for severe infection, I would administer antibiotics. A therapeutic regimen of antibiotics and not prophylactic antibiotics should be utilized.

DR. JONES: If she were afebrile I would use a single drug such as ampicillin. If she were febrile I

would add an aminoglycoside.

DR. CROMARTIE: I would use one of the newer cephalosporins.

DR. MEEKS: Ampicillin treatment was begun, and the patient had an uncomplicated hospital course. She was discharged five days following delivery. The infant had moderately severe hyaline membrane disease which resolved in six days but had no evidence of infection. The infant was discharged one month following delivery.

I would like to thank our panelists for participating in our Grand Rounds and for the lively enlightening discussion. ★★★

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References: 1. Williams RL, Karacan I: Introduction, chap. 1, in *Sleep Disorders: Diagnosis and Treatment*, edited by Williams RL, Karacan I, Frazier SH. New York, John Wiley & Sons, 1978, p. 2. 2. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 3. Kales A et al: *JAMA* 241:1692-1695, Apr 20, 1979. 4. Kales A et al: *J Clin Pharmacol* 17:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. 5. Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 6. Kales A et al: *Clin Pharmacol Ther* 19:576-583, May 1976. 7. Kales A, Scharf MB, Kales JD: *Science* 201:1039-1041, Sep 15, 1978. 8. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 9. Dement WC et al: *Behav Med* 5(10):25-31, Oct 1978. 10. Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 11. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. 12. Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. 13. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 14. Kales A, Kales JD: *Pharmacol Physicians* 4(9):1-6, Sep 1970. 15. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

The Physician's Sleep Glossary

Some common sleep laboratory terms

poly-som-no-graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la-ten-cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af-ter sleep on-set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to-tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.¹

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.²

re-bound in-som-nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.³

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Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, light-headedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

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The President Speaking

Let's Continue MSMA's Progress

SIDNEY O. GRAVES, JR., M.D.
Natchez, Mississippi

In this first message as your president, I want to tell each of you how much I appreciate the honor you have bestowed upon me. It is one of the highlights of my life, ranking with my marriage and the birth of my children.

This is our association's 125th anniversary year, and we should be proud of its long history of service to the profession and citizens of this state. Help me to make 1982-83 a good year for MSMA.

Our organization has seen many achievements and much progress in the past few years. There are none, however, more important than our continuous growth in membership. The fact that we have over 2,000 members is no reason to rest on our laurels. MSMA has much to offer the Mississippi physician. One of my first acts as your president will be to call a meeting of our vice-presidents and president-elect to formulate a program to continue and increase our membership growth.

On other matters, since the leadership conference in Jackson this past March was such an excellent program, we will conduct a similar program this year (even though the name may be slightly different) and seek better participation from all of you. You don't have to be an officer or a delegate to profit from such a meeting.

There are other important plans in the embryonic stage — all for the good of you as members of this association.

One of my main goals this year will be to formulate a program with our Auxiliary to get your participation in our 1983 state elections. We need to contact candidates as we have never done before.

It is said that for lobbying to be successful you must first "get the attention" of the association's members. We want your attention on elections next year that will affect the future of our profession. This can best be done as a partnership effort with our spouses through the Auxiliary. I have discussed this project with Nancy Martin, president of the MSMA Auxiliary, and she promises full cooperation.

We need friends in the Legislature. Next year is the time to support old friends and to make new friends. If we are successful, we might even "get the attention" of the Legislature itself. It is worth a try.

Thank you again for the trust you have placed in me. I promise that I will do my best to merit the honor of serving as your president, and with your help, make this one of the best years in the history of this association.

★★★

EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XXIII, Number 6

JUNE 1982

Delegates Change Nominating Process

At the recent 125th annual session of the Mississippi State Medical Association, the House of Delegates passed the recommendation of the President and Reference Committee on Constitution and Bylaws to amend the bylaws regarding the nominating process for filling vacancies at the annual session. In past years, the policy of nominating at the annual session limited interest and participation in the nomination process. On occasions, it would be difficult to get names to fill all nominations. The bylaws change will mandate that the Nominating Committee will be a working committee and that it will meet at least ninety days prior to the annual session to select candidates for all positions to be vacated at the upcoming session. The list of nominees developed by the committee must be published to the entire membership at least sixty days prior to the annual session.

In addition to mandating the time schedule of the committee functions, it also charges that a member of the Nominating Committee will discuss the office with any person to be nominated, and further mandates that the person to be nominated has expressed a desire to be nominated and has agreed to serve if elected.

These changes do several significant things. First, they give meaning and direction to the nominating process and places a major responsibility on each member of that committee to duly serve the needs of the district he represents. Secondly, the membership in general is required to inform themselves well prior to the annual meeting and to duly serve if elected.

To assist and enhance the efforts of the Nominating Committee working under the new framework, all members and component societies are urged to now begin looking forward to next year's elections, inform themselves of all upcoming vacancies, seek appropriate candidates for all such vacancies, and be ready to assist your member of the Nominating Committee in meeting the requirements as outlined in the recent changes of the bylaws.

MYRON W. LOCKEY, M.D.
Associate Editor

Medico-Legal Brief

Hospital Not Required To Accept Chiropractors

A county hospital was not required to adopt procedures for admission of chiropractors or naturopaths to staff privileges, an Oregon appellate court ruled.

In March, 1979, a chiropractor and naturopath requested hospital privileges at the county general hospital, the only licensed private or public hospital in the county. He was informed that there were no procedures by which such a request could be considered. He was permitted to submit a formal application for appointment to the medical staff. The medical staff then voted unanimously not to amend its bylaws to allow application by chiropractors. The chiropractor filed suit for a declaration that the county hospital was required to adopt reasonable rules and regulations for the admission of chiropractors and naturopaths to staff privileges. A trial court so ordered, but the appellate court reversed.

The appellate court said that no state law or administrative regulation required health care facilities to adopt procedures to grant privileges to chiropractors or naturopaths. The statute and rule referred to by the chiropractor only provided that privileges must be extended to physicians licensed by the Board of Medical Examiners. The chiropractor was licensed by a different Board, the court noted. — *Samuel v. Curry County*, 639 P.2d 687 (Ore. Ct. of App., Jan. 25, 1982)

JOIN  TODAY

PERSONALS

HANS ADAMS of Gulfport announces the association of WARREN A. HIATT, JR., for the practice of gastroenterology.

GUY D. CAMPBELL of Jackson has joined Jackson Medical Associates for the practice of pulmonary disease.

WALLACE CONERLY of UMC was a speaker at the Barnard Millington Symposium on Southern Science and Medicine in Oxford in March and at the American Association for Respiratory Therapy meeting in Stevens Point, Wisconsin, in April.

CLAUDE EARL FOX of Jackson has been chosen to serve on the National Task Force to recommend changes in the distribution of the Maternal and Child Health Block Grant monies and he will also serve on the Maternal and Child Health Data Committee.

ALAN FREELAND of UMC was on the faculty for a recent course on internal fixation in Vail, Colorado.

RAYMOND F. GRENFELL, JR. of Jackson has been board certified in endocrinology and metabolism.

JAMES HUGHES of UMC was on the faculty for a course on internal fixation in Vail, Colorado, and was a member of the faculty for a continuing education workshop in Colorado Springs.

J. T. JANES of McComb was lecturer at Southwest Mississippi Junior College.

FRANKLIN D. JONES announces the opening of his office for the practice of psychiatry at 110 South 10th Avenue in Hattiesburg.

HERBERT LANGFORD of UMC was speaker for a meeting of the Delta Medical Society in Greenville and was lecturer at Campbell Soup Company's recent Symposium on Food, Nutrition and Health in Newark, New Jersey.

WILLIAM W. MAYERS announces the opening of his office for the practice of urology at Starkville Urology Clinic in Starkville.

RODNEY MEEKS and JOHN MORRISON, both of UMC, presented a paper at a meeting of the Society of Gynecological Investigation in Dallas in March.

RUDOLF NUNNEMANN announces the opening of his office for the practice of urology at Doctors' Plaza in Corinth.

ANDREW PARENT of UMC presented a paper at a recent meeting of the American Association of Endocrine Surgeons in Houston, Texas, in April.

WILLIAM PINKSTON of UMC lectured at the Delta Medical Center in Greenville in April.

CLIFFORD A. SEYLER announces his association with DON H. LA GRONE, III, for the practice of pediatrics at 4211 Hospital Road in Pascagoula.

ANCEL C. TIPTON, JR. of Jackson announces the opening of his office for the practice of neurology at 971 Lakeland Drive, Suite 500.

GUY T. VISE, JR. of Jackson has been elected to two offices in the Southern Medical Association — vice chairman of the Council and vice chairman of the Section on Orthopedic Surgery.

W. W. WALLEY of Waynesboro has been reappointed to the State Board of Medical Licensure by Governor William Winter.

WINFRED WISER of UMC has been elected chief of staff. Other officers are R. ALEX SANFORD, vice chief of staff, RALPH VANCE, secretary.

DEATHS

LAMB, JONES WELDON, Greenwood. Born Paragould, AR, Aug. 26, 1915; M.D., Tulane University School of Medicine, New Orleans, 1938; interned Kansas City General Hospital, one year; contagious diseases residency, same, 1939-1940; surgery residency, Vicksburg Clinic and Lutheran Hospital, 1950-1954; died April 2, 1982, age 66.

MESSINA, ALFRED JOSEPH, Vicksburg. Born Vicksburg, MS, Sept. 4, 1912; M.D., Tulane University School of Medicine, New Orleans, 1936; interned French Hospital, New Orleans, one year; died March 28, 1982, age 69.

POWELL, JOHN CANADA, Senatobia. Born Louisville, MS, Feb. 5, 1909; M.D., University of Tennessee College of Medicine, Memphis, 1934; interned Southern Baptist Hospital, New Orleans, one year; died March 4, 1982, age 73.

JOURNAL MSMA encourages your participation. Comments, inquiries and suggestions are invited.

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WARNINGS

Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients.

Use in Pregnancy—Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

PRECAUTIONS

Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

ADVERSE REACTIONS

Hydroflumethiazide—Skin-rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation.

Reserpine—Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares.

USUAL DOSE

The usual adult dose of Salutensin is one tablet once or twice daily. If a smaller amount of thiazide diuretic is desired, Salutensin-Demi, one tablet once or twice daily can be given.

SUPPLIED

Bottles of 10 and 1000 scored tablets.

REFERENCES

1. Propranolol in the treatment of essential hypertension. Veterans Administration Cooperative Study Group on Antihypertensive Agents. *JAMA* 237:2303-2310, 1977.
2. Five-year findings of the hypertension detection and follow-up program: I. Reduction in mortality of persons with high blood pressure, including mild hypertension. Hypertension Detection and Follow-up Program Cooperative Group. *JAMA* 242:2562-2571, 1979.
3. Moser M, Kaplan NM, Sullivan JM, Paul O, in discussion: Perspectives on MRFIT: Can the interim data be applied to your practice...? An Interim Report on the Ongoing Multiple Risk Factor Intervention Trial: MRFIT. *New Perspectives on Hypertension* 2(1):10-19, February 1981.

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NEW MEMBERS

BARRETT, GENE RICHARD, Jackson. Born McComb, MS, Feb. 20, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned University Medical Center, Jackson, one year; orthopedic surgery residency, same, 1975-76; orthopedic surgery residency, University of Greenville Hospital System, Greenville, SC, 1976-79; sports medicine fellowship, Switzerland Jan.-March 1980; sports medicine fellowship, Columbus, GA, May 1980-June 1981; elected by Central Medical Society.

BOLLING, BARBARA ANN, Gulfport. Born Dalton, GA, Dec. 8, 1949; M.D., Tulane University School of Medicine, New Orleans, 1974; interned Emory, Atlanta, Ga., one year; ob-gyn residency, same, 1976-1979; elected by Coast Counties Medical Society.

BUTTROSS, CAROLYN M., Ocean Springs. Born Providence, RI, June 27, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned University Medical Center, Jackson, one year; pediatric residency, same, 1972-74; elected by Singing River Medical Society.

CANNON, CHARLES RONALD, Jackson. Born Hattiesburg, MS, Nov. 22, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned City of Memphis Hospitals, Memphis, one year; general surgery residency, University Medical Center, Jackson, MS, 1977-78; otolaryngology residency, same, 1978-80; otolaryngology residency, Charlottesville, VA, 1980-81; fellowship, facial plastic surgery, Houston, TX, 1981; elected by Central Medical Society.

COSENTINO, DOUGLAS GERALD, Biloxi. Born New Orleans, LA, Oct. 7, 1948; M.D., Louisiana State University School of Medicine, New Orleans, 1974; interned Baptist Hospital, Memphis, one year; radiology residency, same, 1975-78; elected by Coast Counties Medical Society.

HIATT, WOOD COLEMAN, Jackson. Born Little Rock, AR, June 10, 1930; M.D., University of Tennessee College of Medicine, Memphis, 1956; interned McLaren General Hospital, Flint, MI, one year; psychiatry residency, same, 1965-67; fellowship, child psychiatry, Johns Hopkins, Baltimore, 1967-79; elected by Central Medical Society.

HOLDEN, THOMAS E., Grenada. Born Picayune, MS, Nov. 28, 1938; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned University Medical Center, Jackson, one year; ob-gyn residency, same, 1970-73; elected by Northeast Mississippi Medical Society.

LEHMAN, THOMAS WILTON, Gulfport. Born Gulfport, MS, Apr. 11, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned and ob-gyn residency, University Medical Center, Jackson, 1977-81; elected by Coast Counties Medical Society.

MITCHELL, MAURA J., Clinton. Born Cuba, Nov. 30, 1920; M.D., University of Havana, 1946; interned San Antonio, TX, one year 1949; surgery residency, Nashville Baptist Hospital, Nashville, TN, 1950-51 and Lloyd Noland Hospital, Fairfield, AL, 1952-55; elected by Central Medical Society.

ROSE, COLLEEN LOUISE, Ocean Springs. Born Charleston, SC, Aug. 27, 1945; M.D., University of South Carolina College of Medicine, Charleston, SC, 1975; interned and pediatric residency, University Medical Center, Jackson, MS, 1976-78; elected by Singing River Medical Society.

SAULS, LAURA M., Gulfport. Born Jackson, MS, Sept. 27, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned University Medical Center, Jackson, 1973-74; radiology residency, same, 1974-76; radiology residency, University of South Alabama, Mobile 1976-77; elected by Coast Counties Medical Society.

SCHUSTER, CALVIN L., Brandon. Born Starkville, MS, May 21, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned San Joaquin General Hospital, Stockton, CA, 1976-77; surgery residency, same, 1977-81; elected by Central Medical Society.

SMITH, BOBBY DARREL, Hattiesburg. Born San Antonio, TX, Apr. 27, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned University of Louisville Medical Center, Louisville, KY, one year; anesthesiology residency, University of Texas Medical Branch, Galveston, TX 1979-81; elected by South Mississippi Medical Society.

TOWNSEND, DONALD GAYE, Hattiesburg. Born Laurel, MS, Mar. 8, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned William Beaumont Army Medical Center, El Paso, TX, one year; ob gyn residency, same, 1975-78; elected by South Mississippi Medical Society.

WILLIS, ROBERT FREDERICK, Jackson. Born Livingston, WV, July 22, 1920; M.D., University College of Medicine, Richmond, VA, 1951; interned Charleston General Hospital, Charleston, WV, one year; elected by Central Medical Society.

MMFES Presents First Robert S. Caldwell Award



Dr. C. G. Sutherland of Jackson, medical director of the Mississippi Medical Fraternal and Educational Society, presented the first annual Robert S. Caldwell Memorial Award to Dr. Jack B. Foster, Jr., during the recent annual meeting of MMFES.

Dr. Jack B. Foster, Jr., of Jackson received the first annual Robert S. Caldwell Memorial Award sponsored by the Mississippi Medical Fraternal and Educational Society (MMFES). The presentation was made during the MMFES annual meeting, held recently in Biloxi.

The recipient of the annual award is chosen by an ad hoc University Medical Center faculty committee to recognize a physician's in-training excellence in medical practice, patient relations, and documentation of patient care. The award is named in memory of the late Dr. Robert S. Caldwell of Tupelo, president-elect of the Mississippi State Medical Association at the time of his death. Dr. Caldwell, an enthusiastic supporter for the establishment of MMFES, served on the first MMFES Board of Directors.

Dr. Foster is a Hattiesburg native. He was a President's Scholar at Mississippi State University, earning his B.S. degree in chemical engineering. He received his M.D. degree from the University of Mississippi School of Medicine in 1978. After completing a three-year internal medicine residency, he began a two-year cardiology fellowship at UMC. Dr. Foster is married to the former Dana Dameier of New Orleans, and they have two children.

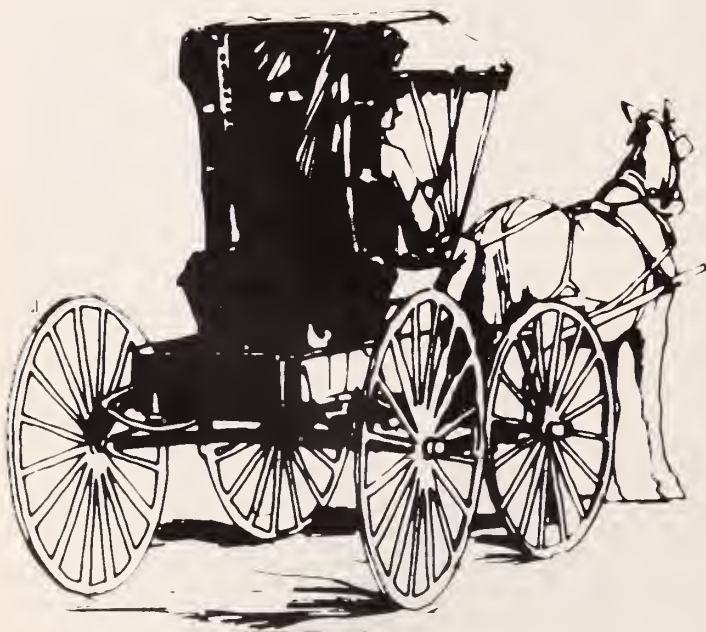
Help Preserve the Heritage Of Medicine in Mississippi

Send your tax-deductible contribution of \$25.00 to help finance construction of a "Country Doctor's Office" at the state's new Agricultural and Forestry Museum in Jackson.

The facility will entertain and educate thousands of visitors to the Capital City each year. Your association's Board of Trustees has endorsed the museum project as an appropriate way to celebrate the MSMA's 125th anniversary year and to tell the story of medicine in Mississippi.

Donors of \$25.00 will receive a limited edition, commemorative plate for office or home.

Donors of \$100.00 or more will receive a plate and will have their names engraved on a plaque at the museum's medical exhibit.



Send your
tax-deductible
contribution
today!

Dr. Sidney O. Graves Is Inaugurated, Dr. Whitman B. Johnson Is Named President-Elect

Dr. Sidney O. Graves of Natchez was inaugurated 1982-83 president at the closing meeting of the 114th Annual Session held last month in Biloxi. He succeeds Dr. R. Faser Triplett of Jackson. Dr. Whitman B. Johnson of Clarksdale was named president-elect.

More than 900 registered for the five-day session, which featured a full program of scientific, business and fellowship activities. This year's schedule included a number of special events to commemorate the association's 125th anniversary year.

The scientific program listed more than 30 speakers from across the country who made presentations during meetings of the 14 scientific sections and 17 medical medical specialty and related organizations.

Highlighting the scientific program was the presentation of the second annual James Grant Thompson Memorial Lecture, which this year was open to the public and was held at the Gulf Coast Convention Center. More than 800 people from the Coast area attended the lecture, a presentation on the Shroud of Turin by Dr. Robert Bucklin of Los Angeles. He



Dr. Sidney O. Graves of Natchez, at right, was inaugurated president of the association during the 114th Annual Session. With him are Dr. Whitman B. Johnson of Clarksdale, at left, 1982-83 president-elect, and Dr. R. Faser Triplett of Jackson, immediate past president.

described the findings of the 40-member team of investigators which in 1978 conducted scientific tests on the shroud, believed to be the burial garment of Jesus Christ. Dr. Bucklin revealed evidence which he believes supports arguments for the authenticity of the relic.

The House of Delegates handled a heavy business agenda which included elections to fill vacancies in MSMA offices, action on more than 25 reports and resolutions, and presentation of awards.

The president, Dr. Triplett, addressed the Monday session of the House of Delegates. He discussed major issues facing the medical profession and made recommendations for MSMA to consider. He outlined the issue of escalating health-care costs and stressed the importance of the medical profession's taking the lead in reducing the increase in those costs. He specifically urged that physicians become knowledgeable about the costs and services they order for their patients and encourage them to consider alternative treatments when appropriate. Commenting on the need for increased public and professional communication in the area of professional liability insurance, he urged that MSMA strive for the enactment of collateral source legislation during the 1983 legislative session.

Dr. Triplett also stressed the need to seek new alternatives in the area of third party reimbursement and commented on the importance of MSMA's new program of meeting with business and community leaders for discussion of that issue and other matters of mutual interest. He recommended continuation of



Dr. James O. Manning, left, chairman of MMPAC, accepts an award from Dr. Dan Cloud, president of the American Medical Association. The plaque represents the first place AMPAC award for ratio of members to potential members.

the MSMA leadership conference, suggested changes in the MSMA election process, and proposed that the Board of Trustees conduct a study of the association's organizational structure. Throughout his address he reiterated the importance of involvement on the personal and local level, a theme which marked his year as president.

During the Thursday session of the House, delegates accepted the reference committee's report for action on the president's suggestions and commended Dr. Triplett for his year of leadership.

Also in the rostrum spotlight was Dr. Daniel T. Cloud, president of the American Medical Association, who addressed the Monday session of the House of Delegates. Commenting on the parallels in his address and the remarks of Dr. Triplett, the AMA president reiterated that the number one issue, as far as health care is concerned, is cost. Emphasizing that the medical profession must provide the leadership in that area, he outlined past and current efforts on the part of the AMA to provide that leadership on a national level. He noted, also, that while the profession is concerned about costs, "we are also concerned about the quality and availability of care." Dr. Cloud said the business/medical coalition movement was an important step in addressing major issues, but he stressed that the coalition movement could not achieve its goals without physician involvement on the local level.



Dr. Whitman B. Johnson, left, administers the oath of office to Dr. Sidney O. Graves, assisted by Charles Mathews, MSMA executive secretary.

He urged physicians to follow the development of the AMA's newly proposed national policy on health care, which would address a number of issues affecting the profession and the public. He called for grass-roots support of AMA's proposed legislation to have Congress define the role and jurisdiction of the Federal Trade Commission.

The AMA president called for a "Crusade for Wellness," noting that half the health care expenditures in the nation (\$125 billion in 1980) were for preventable illness, which he termed "a modern American tragedy." He called for the medical profession to take the lead in educating patients about preventable illnesses caused by smoking, drinking and other lifestyle aberrations, and noted that the greatest opportunity for health care savings and human life preservation is in that area.

Following his prepared address, Dr. Cloud presented to the Mississippi Medical Political Action Committee the first place AMPAC award for ratio of members to potential members. Dr. James O. Manning of Jackson, chairman of MMPAC, accepted the award and encouraged participation by MSMA members in the political action committee.



Dr. John Caden of Jackson, right, received the 1982 MSMA-Robins Award for Community Service from Mr. Willard Duvall, representative of the A. H. Robins Company. The award recognized Dr. Caden's many years of service in medical missions work in needy countries.



Dr. Norman A. Nelson, right, dean of the University of Mississippi School of Medicine, accepts a check for \$24,966.85, representing AMA-ERF contributions to the school from Mississippi physicians, alumni, and their spouses.

Other presentations highlighted the May 3 session of the House of Delegates. Dr. Triplett presented a check for \$24,966.85 to Dr. Norman Nelson, dean of the University of Mississippi School of Medicine. The check represented 1981 AMA-ERF contributions to the school from Mississippi physicians, alumni and their spouses.

Dr. John G. Caden of Jackson was named recipient of the 1982 MSMA-Robins Award for Community Service, in recognition of his many years of service in the medical mission field. He received the award from Dr. Triplett and Mr. Willard A. Duval, representative of the A. H. Robins Company.

Election Results

In addition to electing Dr. Whitman B. Johnson to the post of president-elect, delegates cast ballots to elect other MSMA officers.

Dr. Virginia Tolbert of Ruleville was elected to the Board of Trustees, representing District 1, and Drs. W. Joe Burnett and William C. Gates were re-elected to the Board, representing District 2 and District 3.

In other elections, delegates named Dr. Lee Rogers of Tupelo, Dr. Barry W. Holcomb of Vicksburg, and Dr. William L. Bass, Jr., of Gulfport to terms of office as vice presidents.

Dr. J. Elmer Nix of Jackson was elected to

another term as MSMA secretary-treasurer, and Drs. W. Lamar Weems of Jackson and J. Ed Hill of Hollandale were re-elected delegate and alternate delegate to the AMA.

Elected to a two-year term as associate editor of JOURNAL MSMA was Dr. Arthur A. Derrick, Jr., of Durant.

Three-year terms on the Council on Budget and Finance will be filled by Drs. Bruce M. Kuehnle of Natchez and Dr. J. George Smith of Jackson. Dr. Everett H. Crawford of Tylertown was elected to the Council on Constitution and By-Laws.

Other council posts will be filled by Drs. Joe E. Johnston of Mt. Olive, William E. Godfrey of Natchez, and Tom R. Singley of Pascagoula (Judicial Council); Drs. G. Ray Braswell of Grenada, William C. Ashford of Jackson and Richard M. Vise of Meridian (Council on Legislation); Drs. Milam S. Cotten of Hattiesburg, Ralph L. Brock of McComb, and Katharine A. Pyron of Gulfport (Council on Medical Education); and Drs. David M. Owen of Hattiesburg, Louie F. Wilkins of Brookhaven and Robert F. Carter of Biloxi (Council on Medical Service).



A specially-designed cake recognizing MSMA's 125th anniversary year was a feature of the Hospitality Center during the recent annual session.



House of Delegates in session.

114th Annual Session, May 2-6, 1982

HOUSE OF DELEGATES HANDLES BUSY AGENDA

The House of Delegates of the Mississippi State Medical Association handled a busy agenda of reports and resolutions at the 114th Annual Session of the association in Biloxi. The official transactions of the meeting will be mailed to all delegates.

The MSMA House of Delegates took these major actions:

- Urged the State Board of Health to direct its activities toward the provision of preventive health services normally classified as public health and to assure that its activities in providing therapeutic care adhere to the highest standards of care and do not duplicate services provided by the private sector. The House of Delegates also urged closer communication between the State Board of Health and local physicians.
- Approved a dues increase of \$25.00 effective with 1983 dues.
- Supported enactment of an association-sponsored program to receive and resolve patient complaints about medical services.
- Called for appointment of a special association committee to remove drivers under the influence of alcohol and other mood-altering substances from the highways of Mississippi.
- Supported the Mississippi Foundation for Medical Care conducting peer review on behalf of industry and third party payors.
- Approved a study of the association's organizational structure.
- Supported enactment of collateral source legislation by the 1983 Mississippi Legislature.
- Supported an immunization campaign for congenital rubella syndrome.
- Enacted a nominating process to select and publicize candidates for vacancies in offices of the association at least 60 days prior to the annual session.
- Adopted recommendations of the Board of Trustees that no new scientific sections be authorized and no reimbursement be made for out-of-state speakers until the Board completes a study of criteria for new and continuing sections of the association.
- Endorsed the continuation of an annual association conference on medical socio-economic issues.
- Endorsed the goals of the UMC Poison Services Program and urged voluntary contributions for support of the program.
- Received an amendment to the MSMA Constitution increasing the term of office of vice president of the association from one to three years.
- Approved transfer of Yazoo County from Central Medical Society to Delta Medical Society.
- Presented \$24,966.85 to the University of Mississippi School of Medicine representing 1981 AMA-ERF contributions to the school from Mississippi physicians, alumni, and their spouses.
- Presented the 1982 MSMA-Robins Award for Community Service to Dr. John G. Caden of Jackson.

The Reference Committee on Credentials reported seating 108 delegates at the opening session of the House of Delegates on May 3 and 112 delegates at the closing session on Thursday, May 6.

Serving on reference committees of the House were:

Reference Committee on Rules and Order of Business

Stanley A. Hill, M.D., Chairman
S. Lamar Bailey, M.D.
Joe Johnston, M.D.

Reference Committee on Reports of Officers, Board of Trustees and Councils

Martin H. McMullan, M.D., Chairman
Dewey H. Lane, Jr., M.D.
W. T. Lamar, M.D.
Thomas S. Parvin, M.D.
Mal Morgan, M.D.

Reference Committee on Constitution and Bylaws

Mary Ward, M.D., Chairman
Frederick E. Tatum, M.D.
George D. Purvis, M.D.

Credentials Committee

J. Elmer Nix, M.D., Chairman
Stanley Hartness, M.D.
Fred McMillan, M.D.

Nominating Committee

C. R. Jenkins, M.D., Chairman
Virginia Tolbert, M.D.
Horton Taylor, M.D.
William B. Howard, M.D.
Arthur A. Derrick, M.D.
Myron Lockey, M.D.
Richard Vise, M.D.
Mal Morgan, M.D.
Roy Duncan, M.D.

Dr. Sidney O. Graves, Jr. of Natchez is MSMA's 1982-83 president; Dr. Whitman B. Johnson, Jr., of Clarksdale was elected president-elect.

Newly elected or re-elected officers, Council and Board members are: Drs. J. Elmer Nix, secretary-treasurer; Lee Rogers, Barry W. Holcomb and William L. Bass, Jr., vice presidents; W. Lamar Weems, AMA delegate; J. Ed Hill, AMA alternate delegate; A. A. Derrick, Jr., associate editor; Bruce M. Kuehnle and J. George Smith, Council on Budget and Finance; Everett H. Crawford, Council on Constitution and By-Laws; Joe E. Johnston, William E. Godfrey, III, and Tom R. Singley, Judicial Council; G. Ray Braswell, William C. Ashford and Richard M. Vise, Council on Legislation; Milam S. Cotten, Ralph L. Brock and Katherine A. Pyron, Council on Medical Education; David M. Owen, Louie F. Wilkins and Robert F. Carter, Council on Medical Service; and Virginia S. Tolbert, W. Joe Burnett and William C. Gates, Board of Trustees.

115th Annual Session May 11-15, 1983 (Wednesday-Sunday) Royal D'Iberville Hotel, Biloxi



Dr. Carl G. Evers of Jackson presided as speaker of the House of Delegates.



Mrs. James Grant Thompson presented the Past President's Pin to Dr. Triplett.



Dr. James E. Waites of Laurel served as vice-speaker of the House of Delegates.



Dr. Triplett, left, received a certificate of appreciation for his year of service as MSMA president. With him is Dr. Paul H. Moore of Pascagoula, immediate past president, who made the presentation at the annual past presidents' breakfast.

Board of Trustees Elects New Officers

A new name appears on the roster of Mississippi State Medical Association trustees, and it marks the first time a woman has been elected to the Board of Trustees.

During the 114th Annual Session held last month in Biloxi, delegates elected Dr. Virginia S. Tolbert of Ruleville to the board, representing District 1. Drs. W. Joe Burnett of Oxford and William C. Gates of Columbus were re-elected to terms as trustees, representing District 2 and District 3.

Meeting at the conclusion of the annual session, board members elected Dr. Ellis M. Moffitt of Jackson as chairman and Dr. Roy D. Duncan of Pascagoula as secretary.

Other members of the board are Drs. W. Boyce White of Laurel, William B. Hunt of Grenada, James O. Manning of Jackson, George L. Arrington, Jr., of Meridian, and David R. Steckler of Natchez.

Six general officers meet with the trustees: president-elect, secretary-treasurer, speaker of the House of Delegates, vice speaker, and the two AMA delegates.



Dr. Virginia Tolbert of Ruleville was elected to the Board of Trustees, representing District 1.



Members of the reference committees were briefed on their responsibilities during a breakfast. From left are Dr. Dewey H. Lane of Pascagoula, Dr. Mal G. Morgan of Natchez, Dr. Fred L. McMillan of Jackson, Dr. T. S. Parvin of Starkville, and Dr. Mart McMullan of Jackson.



Among reference committee members who attended a breakfast meeting to receive instructions on their committees' functions were, from left, Dr. Stanley Hill of Tupelo, Dr. Mary Ward of Corinth, Dr. Frederick E. Tanum of Hattiesburg, and Dr. Sidney O. Graves of Natchez, MSMA president-elect.

Special Events Highlight Annual Session Calendar

The calendar of special events scheduled during the recent 114th Annual Session provided a variety of activities for MSMA and MSMA Auxiliary members and guests to enjoy.

In addition to the annual tennis tournament, the golf tournament, and a two-day fishing rodeo were a number of special events to commemorate the association's 125th anniversary year.

A banquet on Wednesday night recognized past presidents of the association, and was a real "birthday party," complete with balloons, a cake, and party favors (engraved key rings) which were presented to those who attended the occasion. Members and guests also received copies of the third edition of the *MSMA History*, published in recognition of the anniversary. A special exhibit of medical artifacts was on display during the entire session. Throughout the week convention registrants were invited to the Auxiliary's Hospitality Center, which each day featured a specially designed anniversary cake.

The annual MSMA and MSMA Auxiliary membership banquet, featuring Abigail Van Buren (Dear Abby) as guest speaker, was held on Tuesday night.

(Continued on page 185)



Balloons, party favors, and costumes were part of the 125th anniversary celebration. Above are Dr. Sidney O. Graves of Natchez and Mrs. James Grant Thompson of Jackson.



Abigail Van Buren (Dear Abby) was special guest speaker at the annual MSMA/MSMA Auxiliary membership banquet. Pictured at the head table are, from left, Dr. Faser Triplett, Miss Van Buren, Mrs. Triplett, and Dr. and Mrs. Paul Moore of Pascagoula.



MSMA past presidents and their wives were recognized at a dinner celebrating the association's 125th anniversary.



Special Events at Annual Session

(Continued from page 183)

Medical alumni organizations from Tulane, the University of Tennessee, and the University of Mississippi hosted receptions on Monday night. The annual MSMA President's Reception, sponsored by the Great Southern National Bank, was held on Sunday night.

Winners of the golf tournament, sponsored by South Central Bell, received trophies at an awards reception held on Tuesday afternoon. Dr. Swink Hicks of Natchez and Dr. J. Elmer Nix of Jackson won first and second place low net. Low gross winners were Dr. Shelby Smith of McComb, first place, and Dr. Ray Orgler of Starkville, second place. Dr. George Arrington of Meridian received the trophy for longest drive and Dr. Fred McMillan of Jackson received the trophy for closest-to-the-pin.

Dr. James O. Manning of Jackson was chairman of the annual tennis tournament, sponsored by the Mississippi Medical Fraternal and Educational Society (MMFES). Receiving trophies for doubles competition were Dr. William L. Seidensticker and Dr. Carol A. Smith of Gulfport, and Dr. Thomas Whitehead of Columbia and Dr. John Estess of Hollandale, runners-up. Dr. Ben F. Sanford, Jr., of Starkville and Dr. Richard Vise of Meridian won the mens' doubles consolation trophy. Winning trophies

in women's doubles competition were Mrs. Douglas Godfrey and Mrs. Lamar Weems of Jackson, first place, and Dr. Betty M. Bailey of Gulfport and Dr. Camille J. Jeffcoat of Columbus, runners-up.

Fishing rodeo trophies were presented to Dr. and Mrs. S. J. McDuffie of Nettleton (largest jack crevalle) and to Mrs. James Grant Thompson of Jackson (largest Spanish mackerel).



Dr. Swink Hicks of Natchez displays the trophy he received for winning the golf tournament.



Dr. and Mrs. S. Jay McDuffie of Nettleton show off the winning jack crevalle following the fishing rodeo.



Mrs. Doug Godfrey and Mrs. Lamar Weems receive winning trophies from Dr. James O. Manning, chairman of the annual tennis tournament.



Mrs. James Martin of Ocean Springs, seated at center, was installed as 1982-83 president of the MSMA Auxiliary. Mrs. Stanley Hartness of Kosciusko, seated at left, is president-elect, and Mrs. Terrell Blanton of Brandon, at right, is first vice president. Other officers, standing from left, are Mrs. Louis A. Rubenstein of Ocean Springs, second vice president; Mrs. James C. Waites of Laurel, third vice president; Mrs. Enrique Flechas of Natchez, fourth vice president; Mrs. Floyd Lummus of Tupelo, recording secretary; and Mrs. Joe Herrington of Natchez, treasurer.

MSMA Auxiliary Conducts 59th Annual Session

The general meeting of the Mississippi State Medical Association Auxiliary's 59th Annual Session took place on Tuesday, May 4, at the Biloxi Hilton. Mrs. James Martin of Ocean Springs was installed as president, succeeding Mrs. John Estess of Hollandale. Mrs. Stanley Hartness of Kosciusko was named president-elect.

Other officers for 1982-83 include: Mrs. Terrell D. Blanton of Brandon, first vice-president; Mrs. Louis A. Rubenstein of Ocean Springs, second vice-president; Mrs. James Waites of Laurel, third vice-president; Mrs. Enrique Flechas of Natchez, fourth vice-president; Mrs. Floyd Lummus of Tupelo, recording secretary; Mrs. Joe Herrington of Natchez, treasurer; Mrs. James Grace of Ocean Springs, corresponding secretary; and Mrs. A. T. Tatum of Hattiesburg, parliamentarian.

Special guests attending the auxiliary meeting were Mrs. Philip L. Smith, first vice-president of the American Medical Association Auxiliary, and Mrs. Keith Jones, president of Southern Medical Auxiliary.

Twelve Members Attend Fifty Year Club Luncheon

Members of the Fifty-Year Club were entertained at a luncheon in their honor during the association's 114th Annual Session in Biloxi. Dr. Whitman B. Johnson of Clarksdale, chairman of the Board of Trustees, hosted the occasion.

Twelve club members attended this year's meeting, including: Dr. Harvey T. Garrison of Jackson; Dr. Eldon L. Bolton of Biloxi; Dr. S. Lamar Bailey of Kosciusko; Dr. T. F. Clay of Tutwiler; Dr. Samuel Brooks Caruthers of Grenada; Dr. Homer A. Whittington of Natchez; Dr. Guy T. Vise, Sr. of Meridian; Dr. G. T. Sheffield of Gulfport; Dr. Lawrence W. Long of Jackson; Dr. Omar Simmons of Newton; Dr. Stanley A. Hill of Corinth; and Dr. Thomas R. Ramsay of Biloxi.



Dr. Homer Whittington of Natchez, new member of the Fifty Year Club, entertained during the club luncheon.

Council on Scientific Assembly Begins Planning for 1983

The 1983 annual session is set for May 11-15 in Biloxi, according to Dr. J. Elmer Nix of Jackson, chairman of the Council on Scientific Assembly. This summer the council will meet to review preliminary plans and begin work on the program for the 115th Annual Session. Next year's meeting will inaugurate the Wednesday-Sunday format mandated by the House of Delegates in 1981.

Acting by separate sections during the recent annual meeting, the 14 components of the Council on Scientific Assembly named new chairmen, and 10 named new secretaries. Under the bylaws of the association, a section chairman serves a term of one year, but section secretaries are elected for three years to provide continuity.

Each office carries an automatic seat and vote in the House of Delegates to assure proper representation of each specialty.

Dr. Allan Stallings of Jackson was elected to chair the Section on Anesthesiology. Dr. Fred Guidry of Jackson will serve a three-year term as secretary.

Members of the Section on Eye, Ear, Nose and Throat named Dr. Harold K. Hudson of Tupelo as chairman and Dr. William C. Ashford of Jackson as secretary.

Dr. Joseph H. Robinson of Jackson will chair the Section on Dermatology.

Drs. David L. Clippinger and T. E. Benefield, both of Gulfport, were named chairman and secretary of the Section on Family Practice.

The Section on Medicine will be chaired by Dr. Douglas F. Thomas of Hattiesburg. Dr. William A. Long, Jr. of Jackson will be section secretary.

Dr. Fred H. Ingram of Jackson was named chairman of the Section on Obstetrics and Gynecology. Dr. E. J. Price of McComb continues his term as secretary.

Dr. Wayne T. Lamar of Oxford will chair the Section on Orthopedic Surgery, and Dr. Wiley C. Hutchins of Columbus will serve as secretary.

Heading the Section on Pathology will be Dr. J. Larry Smith of Hattiesburg. Dr. Philip Saccoccia of Gulfport continues his term as secretary.

New officers of the Section on Pediatrics are Dr. Clifford A. Seyler of Pascagoula, chairman, and Dr. F. Thomas Carey of McComb, secretary.

Dr. Nan Brantley of Jackson will chair the Section on Psychiatry and Dr. Vincent Liberto of Jackson will serve as secretary.

New officers of the Section on Radiology are Dr. Jeffrey L. Sauls of Ocean Springs, chairman, and

Dr. Laura Sauls of Gulfport, secretary.

Dr. Jerry R. Adkins was elected chairman of the Section on Surgery and Dr. Ralph E. Abraham was named secretary.

Dr. A. C. Jackson, Jr. of Jackson was elected to serve as chairman of the Section on Urology and Dr. James S. Robbins of Greenwood was named secretary.

Ex officio members of the Council on Scientific Assembly are the association president, Dr. Sidney O. Graves of Natchez, and the president-elect, Dr. Whitman B. Johnson of Clarksdale.



New chairman and secretary of the Section on Medicine are, above, Dr. Douglas Thomas of Hattiesburg, at left, and Dr. William Long of Jackson.

Pictured below are Dr. Jeffrey Sauls of Ocean Springs and Dr. Laura Sauls of Gulfport, who were elected chairman and secretary of the Section on Radiology.





Dr. James Hendrix of Memphis, center front, guest speaker for the Mississippi Society of Plastic and Reconstructive Surgery meeting, is flanked by Dr. Heber Etheridge of Jackson, society president, and Dr. Doug Godfrey of Jackson. Standing, left to right, are Dr. William Wallace of Jackson, Dr. Berlyn Edwards of Biloxi, Dr. Michael Jabaley of Jackson, and Dr. John Schimmel, also of Jackson.



Participants in the meeting of the Mississippi Chapter, American College of Surgeons, were, left to right: Dr. Whitman B. Johnson of Clarksdale, chapter president; Drs. J. Alex Haller of Baltimore and James A. O'Neal of Philadelphia, guest speakers; and Dr. Jerry R. Adkins of Biloxi, chapter secretary.



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An added complication... in the treatment of bacterial bronchitis*



Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Cefclor® (cefactor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES. Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefactor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefactor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistix® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefactor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Cefclor.

Hypersensitivity reactions have been reported in about 1.5

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

Cefclor®

cefactor

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percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthritis and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefclor® (cefactor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transient abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). (100281R)

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8:91, 1975.
2. Antimicrob. Agents Chemother., 11:470, 1977.
3. Antimicrob. Agents Chemother., 13:584, 1978.
4. Antimicrob. Agents Chemother., 12:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 13:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.



Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.



Dr. Ralph Ford of Ripley, at right, was elected chairman of the Section on Preventive Medicine. With him is Dr. Alfio Rausa of Greenwood, section secretary.



Dr. Harold K. Hudson of Tupelo, at right, was elected president of the Mississippi EENT Association and chairman of MSMA's Section on EENT. He is pictured with Dr. Bill Mayfield and Dr. Wilson Moak of Jackson, who are the EENT association's vice president and secretary. Not pictured is Dr. William Ashford of Jackson, who was elected secretary of MSMA's Section on EENT.



Dr. Larry Day of Hattiesburg, at right, and Dr. Kenneth Reed of Jackson, at left, are president and vice-president of the Mississippi Academy of Facial Plastic and Reconstructive Surgery. They are pictured with Dr. John McIver Hodges of Memphis, who was speaker for MSMA's Section on EENT. Dr. J. George Smith of Jackson is secretary of the academy.

Cyclapen®-W (cyclacillin)

Indications

Cyclacillin has less *in vitro* activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci

Branchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)

Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*), *H. influenzae*, and Group A beta-hemolytic streptococci

Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS It is not known whether this drug is excreted in human milk. Because many drugs are excreted in milk when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg t.i.d. body weight > 20 kg (44 lbs) 250 mg t.i.d.
Branchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.	50 to 100 mg/kg/day t.i.d.
Skin & Skin Structures	250 mg to 500 mg q.i.d.	50 to 100 mg/kg/day
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults, depending on severity.

How Supplied Tablets 250 mg and 500 mg in bottles of 100. Oral Suspension 125 mg and 250 mg per 5 ml in bottles to make 100 ml and 200 ml of Suspension.

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in children

*Rapidly excreted unchanged in urine.
Clinical efficacy may not always correlate with blood levels.

†Due to susceptible organisms.

1. Ginsburg CM, McCracken GH Jr, Zweighaft TC, Clahsen JC: Comparative pharmacokinetics of cyclacillin and amoxicillin in infants and children. *Antimicrob Ag Chemother* 19:1086-1088 (June) 1981.

2. Multicenter trials. Data to be published.

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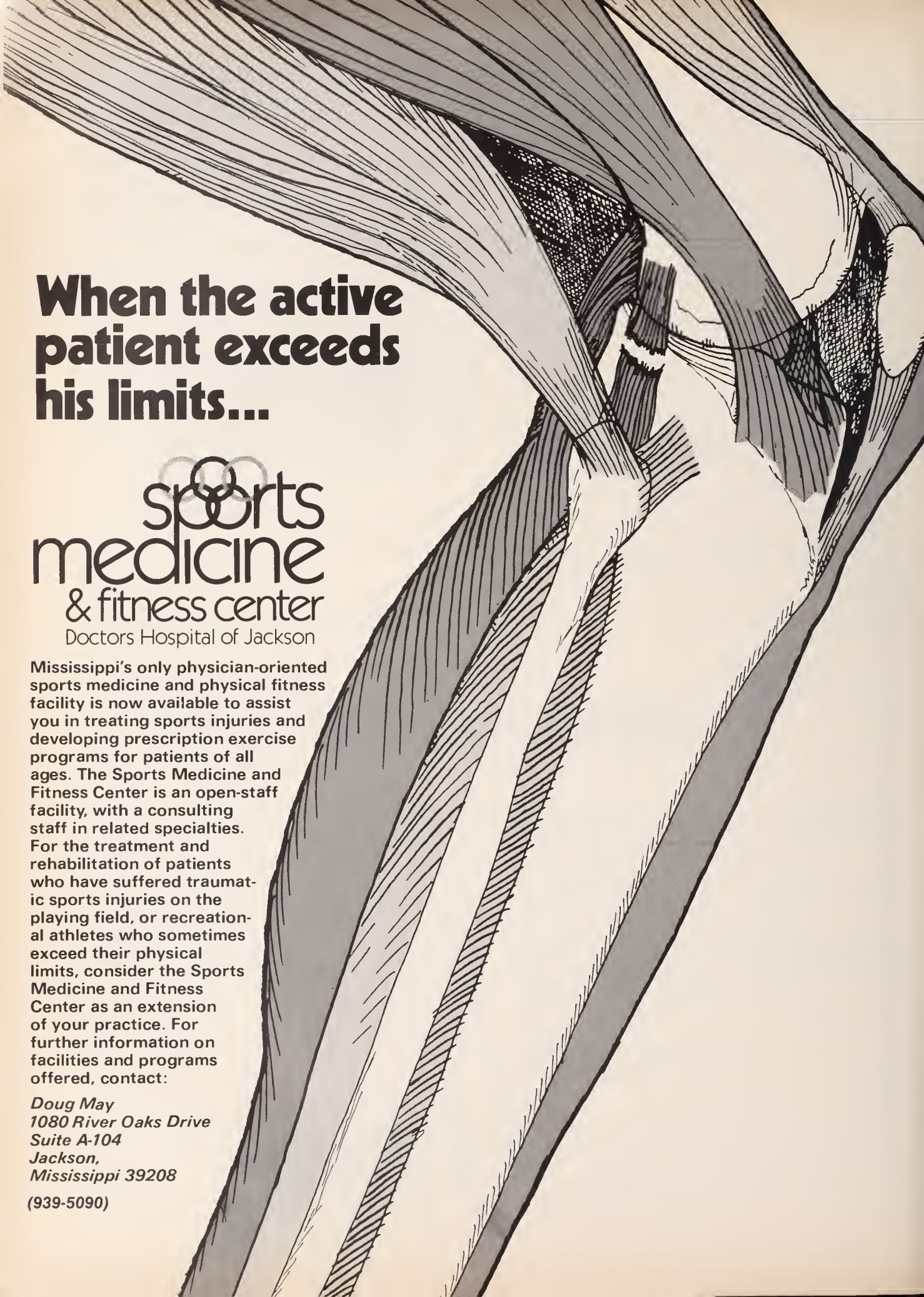
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Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to penicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonia. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warning: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: General: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. Allergic reactions: Erythema

multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. CNS reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

Miscellaneous reactions: Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

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Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

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1. Rubin RH, Swartz MN: *N Engl J Med* 303 426-432, Aug 21, 1980. 2. Data on file, Medical Department, Hoffmann-La Roche Inc.

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* due to susceptible strains of indicated organisms

Please see previous page for summary of product information.

July 1982

JOURNAL
of the **MISSISSIPPI**
State Medical Association



Acute Hepatitis of Secondary Syphilis

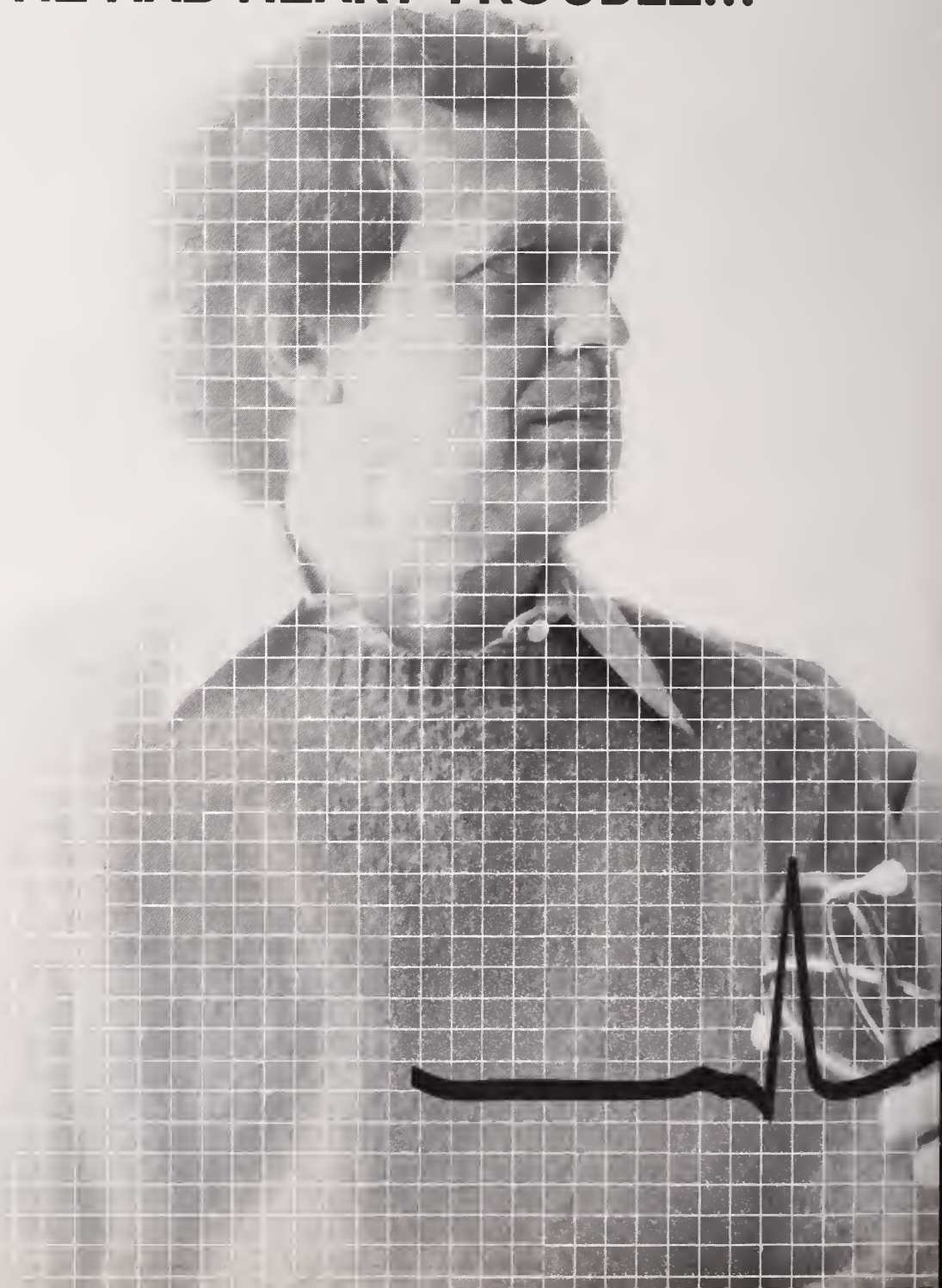
Coronary Angioplasty

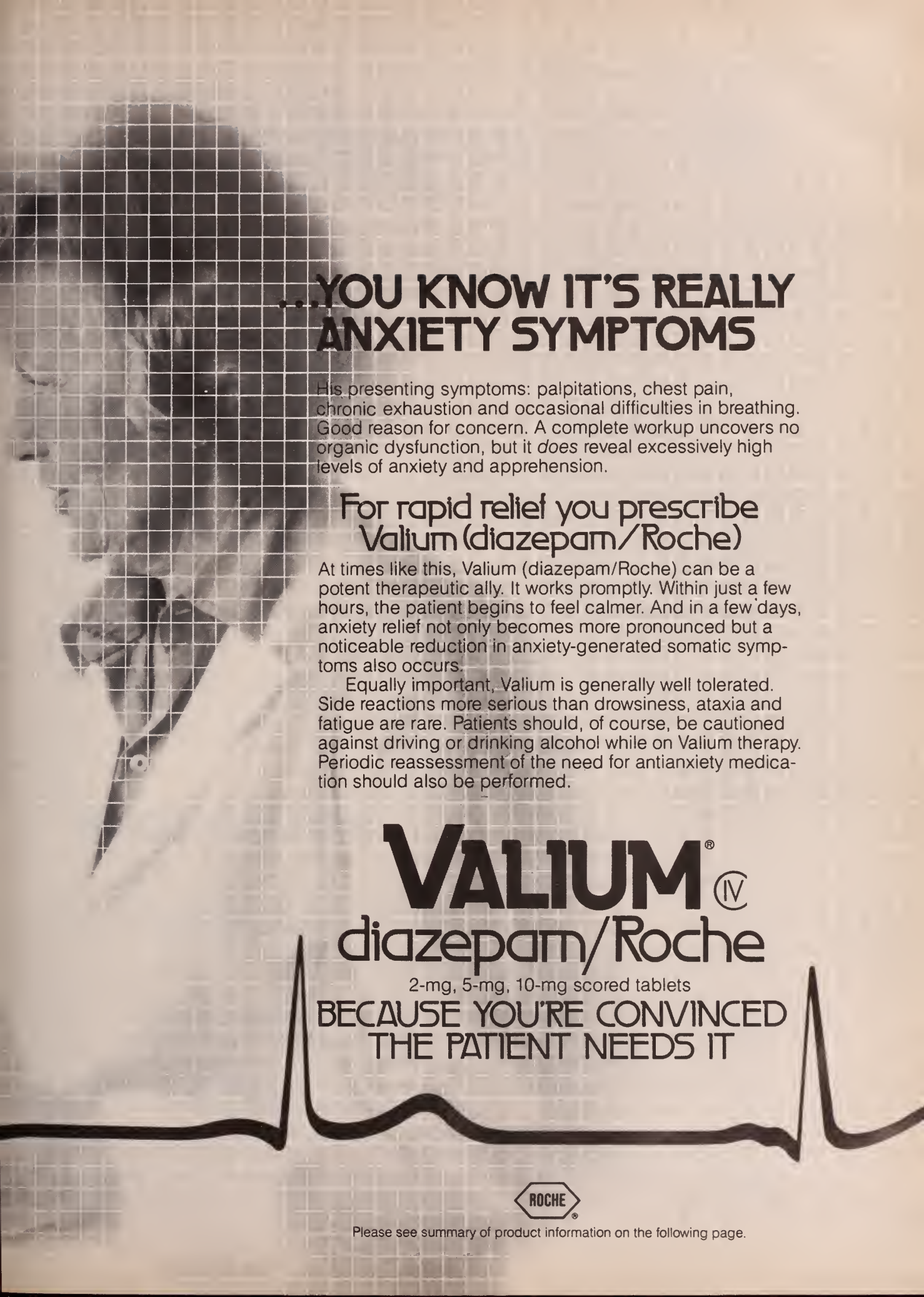
Report from the Mississippi State Board of Health: Genital Herpes

**Radiological Seminar CCXXII:
Bilateral Diffuse Pulmonary
⁶⁷Ga Uptake**

125th Anniversary Year — Mississippi State Medical Association

**THE PATIENT THINKS
HE HAS HEART TROUBLE...**





...YOU KNOW IT'S REALLY ANXIETY SYMPTOMS

His presenting symptoms: palpitations, chest pain, chronic exhaustion and occasional difficulties in breathing. Good reason for concern. A complete workup uncovers no organic dysfunction, but it *does* reveal excessively high levels of anxiety and apprehension.

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2-mg, 5-mg, 10-mg scored tablets

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THE PATIENT NEEDS IT



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VALIUM® (diazepam/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome; convulsive disorders (not for sole therapy). The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

How Supplied: For oral administration, Valium scored tablets—2 mg, white, 5 mg, yellow, 10 mg, blue—bottles of 100* and 500.* Prescription Paks of 50, available in trays of 10.* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25,† and in boxes containing 10 strips of 10.†

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JOURNAL of the MISSISSIPPI State Medical Association



July 1982, Volume XXIII, Number 7

125th Anniversary Year

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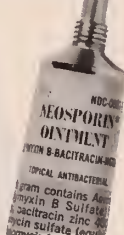
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CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neo-



mycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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NEWSLETTER

July 1982

Dear Doctor:

The Department of HHS has sent notices to all hospitals warning that loss of federal Medicare and Medicaid payments could result from denial of treatment to the handicapped. The letter was a result of the publicized "Infant Doe" case in Indiana where a deformed baby was allowed to die. Secretary Schweiker said "the President has instructed me to make absolutely clear to health providers in this nation that federal law does not allow medical discrimination against handicapped infants."

The letter said in part that "a recipient may not lawfully decline to treat an operable life threatening condition in an infant, or refrain from feeding the infant, simply because the infant is believed to be mentally retarded."

Nine years after its historic decision limiting states' rights to outlaw abortion, the Supreme Court has agreed to review restrictive statutes in three states. The Court is considered more conservative today than it was in 1973 when it held 7-2 that states could not prohibit abortions during the first trimester of pregnancy. The decision is not expected until late this year or next year.

Some 30 of every 100 persons were injured in 1980, reports the National Center for Health Statistics. Two out of every 100 persons were injured in a vehicle accident; 12 were injured in a home related accident. Some 5 of every 100 individuals were injured at work; and 13 out of every 100 were injured by other means, including non-accidental injuries such as homicidal/suicidal attempts.

Congressional action on the question of whether to allow the FTC jurisdiction over the learned professions, including medicine, is approaching, although no firm dates for action have been set. Three bills are under consideration. Mississippi Congressmen Bowen, Dowdy, Lott and Montgomery are sponsoring H.R. 3722; Senators Cochran and Stennis in the past have supported Senate bills limiting FTC authority.

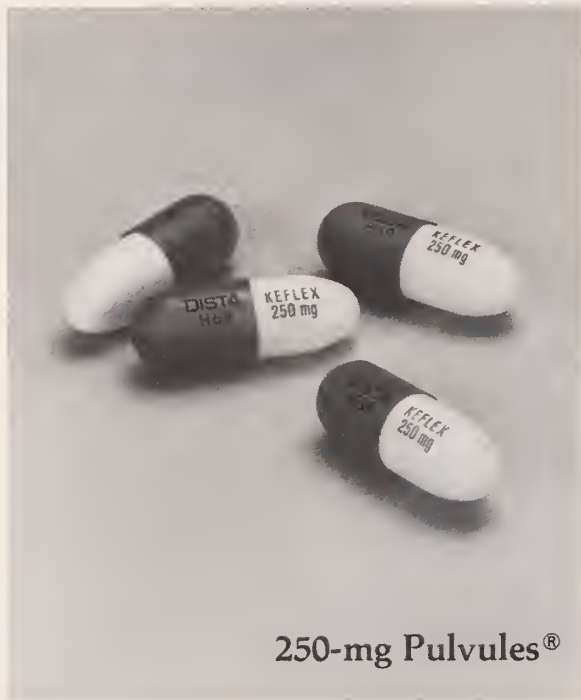
The Council on Scientific Assembly will meet at the MSMA headquarters office on July 29 to plan and schedule activities for the 115th Annual Session, which will inaugurate the new Wednesday-Sunday format. MSMA members are urged to mark their calendars and plan to attend the 115th Annual Session, May 11-15, 1983, in Biloxi. Upcoming issues of Journal MSMA will provide more details.

Sincerely,



Patsy Silver
Managing Editor

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with morning hangover.

Feeling well rested in the morning usually means having slept well the night before. And for insomniac patients receiving hypnotic therapy, a good morning also means awakening with few side effects from their medication. Many physicians choose Dalmane for their patients who suffer from insomnia for this very reason.

Aside from enabling patients to fall asleep more quickly and sleep longer, Dalmane seldom causes morning hangover. Most Dalmane patients feel alert and refreshed when they awaken. In 53 paired-night clinical studies comparing Dalmane and placebo in 2010 insomniac patients with a variety of secondary diagnoses, most Dalmane patients awakened more alert and refreshed, and less groggy and drowsy, than on nights when they had taken only placebo.¹ In a double-blind crossover study of

42 patients in private practice, approximately three times as many patients reported feeling refreshed and alert upon awakening after a night on Dalmane (flurazepam/Roche) compared to placebo nights.² This difference was highly significant ($p < 0.001$). And a retrospective study of 2542 hospitalized patients who received Dalmane revealed only a 3.1% incidence of side effects.³

While residual effects from Dalmane therapy are infrequent, patients should be cautioned about drinking alcohol, driving or operating hazardous machinery after ingesting the drug.

Efficacy and safety in a broad range of patient types.

Over 2000 clinical trials involving more than 10,000 patients have shown that Dalmane patients fall asleep sooner, sleep longer and experience fewer nocturnal awakenings.⁴ The safety and efficacy of Dalmane have been demonstrated in medical and surgical hospitalized patients, in patients seen in office practice and in elderly patients.⁵⁻⁸ Since the risk of oversedation, dizziness, confu-

sion and/or ataxia increases with larger doses in the elderly, it is recommended that the dosage be limited to 15 mg.

Moreover, the efficacy and safety of Dalmane for the treatment of insomnia have been demonstrated in thousands of patients with a variety of primary medical conditions, including cardiovascular, neuropsychiatric, endocrine-metabolic, gastrointestinal, genitourinary, respiratory and musculoskeletal disorders.¹ Dalmane (flurazepam HCl/Roche) is contraindicated in pregnancy and in patients hypersensitive to the drug.

Avoids rebound insomnia upon discontinuation.

Rebound insomnia—a worsening of sleep beyond pretherapy levels after drug discontinuation—has been reported as a potential clinical problem with some hypnotics.^{9,10} However, this problem has not been reported with Dalmane. In eight out of eight sleep laboratory studies, there were no reports of rebound insomnia.¹¹ When you prescribe Dalmane, you can be confident of efficacy that enhances therapeutic progress. Your insomniac patients can be assured of a restful night, night after night—a good start for a good morning.

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 3. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977. 4. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 5. Meyer JA, Kurland KZ: *Milit Med* 138:471-474, Aug 1973. 6. Feffer HL, Gibbons B: *Med Times* 101(8):130-135, Aug 1973. 7. Jacobson A et al: *Psychophysiology* 7:345, Sep 1970. 8. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 9. Kales A, Scharf MB, Kales JD: *Science* 201:1039-1041, Sep 1978. 10. Kales A et al: *JAMA* 241:1692-1695, Apr 1979. 11. Monti JM: *Methods Find Exp Clin Pharmacol* 3(5):303-326, 1981.

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Riverside is licensed by the Mississippi Commission on Hospital Care, and is fully accredited by the Joint Commission on Accreditation of Hospitals.

The medical staff includes a large number of psychiatrists in private practice in the Jackson area. A toll-free number, 1-800-962-2180, has been established at the hospital for referral service to physicians on the active medical staff.

Physicians who have patients who would benefit from the type of treatment approach offered by Riverside may obtain referral information by contacting the Director of Admissions.

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DATELINE

Medical Exhibit Needs Contributions Jackson, MS - More contributions are needed to help build a country doctor's office at the new Agricultural and Forestry Museum, a project endorsed by the MSMA Board of Trustees. Donors of \$25 will receive a limited edition, decorative plate commemorating MSMA's 125th anniversary year. Names of donors of \$100 will be inscribed on a plaque at the exhibit. For more information about where to send your tax-deductible contribution, call the MSMA headquarters office.

MMFES Changes Corporate Name Jackson, MS - On August 1, the new corporate name of the Mississippi Medical Fraternal and Educational Society, Inc. will officially become the Medical Assurance Company of Mississippi, Inc. The organizational structure, philosophy and intent to serve the physicians of Mississippi regarding professional liability insurance will remain the same. The Medical Assurance Company is a non-profit Mississippi corporation sponsored by the MSMA and directed by Mississippi physicians.

AMA Survey Now Underway Chicago, IL - Physicians are urged to cooperate in the AMA's Socioeconomic Monitoring Systems survey, now underway. The more ambitious survey collects a broader range of information and takes an average of 30 minutes, compared with 20 minutes of previous surveys, and the survey is collecting information from 4,000 physicians rather than 1,200 as in the past. The first quarter survey began July 1 and continues through August 27. Target date for completion is June 18, 1983.

Physicians Voice Career Concerns Chicago, IL - About half of the nation's physicians say they would not recommend medicine as highly today as in the past, according to a recent survey. The report said the figures reflect pessimism about the future of medicine, rather than personal dissatisfaction about career choices. Frequently cited concerns were loss of autonomy, decreased personal satisfaction caused by malpractice suits, defensive medicine, loss of public respect, and erosion of physician-patient relationships.

Mental Health Needs Described Jackson, MS - An estimated 100,000 Mississippi children under the age of 18 are in need of some type of mental health care, says a Mental Health Association newsletter which reports: last year 4,800 children were new admissions to community mental health centers; there was an increase in child abuse and in teenage suicides and suicide attempts; 188 children were admitted to one of the state's two mental hospitals; an estimated 60% of state high school students regularly use drugs.

HYPERTENSION:



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CONTRAINDICATIONS

INDERAL is contraindicated in: 1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

WARNINGS

CARDIAC FAILURE. Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta-blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. INDERAL acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by INDERAL's negative inotropic effect. The effects of INDERAL and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during INDERAL therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, INDERAL therapy should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS DURING ANESTHESIA with agents that require catecholamine release for maintenance of adequate cardiac function, beta blockade will impair the desired inotropic effect. Therefore, INDERAL should be titrated carefully when administered for arrhythmias occurring during anesthesia.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, INDERAL should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since INDERAL is a competitive inhibitor of beta receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA) INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA. Because of its beta-adrenergic blocking activity INDERAL may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY. The safe use of INDERAL in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit.

Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of INDERAL may produce hypotension and/or marked bradycardia resulting in vertigo, syncope attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to cataplexy, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Miscellaneous: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

ORAL

DOSAGE AND ADMINISTRATION

HYPERTENSION. Dosage must be individualized. The usual initial dosage is 40 mg INDERAL twice daily, whether used alone or added to a diuretic. Dosage may be increased gradually until adequate blood pressure is achieved. The usual dosage is 160 to 480 mg per day. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

While twice-daily dosing is effective and can maintain a reduction in blood pressure throughout the day, some patients, especially when lower doses are used, may experience a modest rise in blood pressure toward the end of the 12 hour dosing interval. This can be evaluated by measuring blood pressure near the end of the dosing interval to determine whether satisfactory control is being maintained throughout the day. If control is not adequate, a larger dose, or 3 times daily therapy may achieve better control.

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

INTRAVENOUS

The intravenous administration of INDERAL has not been evaluated adequately in the management of hypertensive emergencies.

OVERDOSAGE OR EXAGGERATED RESPONSE

IN THE EVENT OF OVERDOSAGE OR EXAGGERATED RESPONSE THE FOLLOWING MEASURES SHOULD BE EMPLOYED:

BRADYCARDIA: ADMINISTER ATROPINE (0.25 to 1.0 mg). IF THERE IS NO RE-

SPONSE TO VAGAL BLOCKADE: ADMINISTER ISOPROTERENOL CAUTIOUSLY.

CARDIAC FAILURE: DIGITALIZATION AND DIURETICS.

HYPOTENSION: VASOPRESSORS, e.g., LEVATERENOL OR EPINEPHRINE (THERE IS EVIDENCE THAT EPINEPHRINE IS THE DRUG OF CHOICE).

BRONCHOSPASM: ADMINISTER ISOPROTERENOL AND AMINOPHYLLINE.

HOW SUPPLIED

INDERAL (propranolol hydrochloride)

TABLETS

No. 461 Each scored tablet contains 10 mg of propranolol hydrochloride in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 462 Each scored tablet contains 20 mg of propranolol hydrochloride in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 464 Each scored tablet contains 40 mg of propranolol hydrochloride in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 468 Each scored tablet contains 80 mg of propranolol hydrochloride in bottles of 100 and 1,000. Also in unit dose package of 100.

INJECTABLE

No. 3265—Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10.

Reference: 1 Freis, E.D. Hypertension (Suppl. II) 3:230 (Nov-Dec) 1981.

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ORIGINAL PAPERS

Acute Hepatitis of Secondary Syphilis

JACK Q. CAUSEY, M.D.

Centreville, Mississippi

LIVER DISEASE OCCURRING as a manifestation of early syphilis is unusual.¹⁻³ Rarely hepatitis and jaundice are seen⁴ but this association is not readily recognized or considered in the differential diagnosis of obscure hepatic diseases.¹⁻² A patient with secondary syphilis and acute hepatitis is the object of this case report.

Report of a Case

A 22-year-old black male was seen on March 16, 1981, with a history of upper abdominal pain, anorexia, nausea, malaise and low grade fever for one week. Three weeks before onset of symptoms he developed a lesion involving the corona of the glans penis and a few days before he was first seen, he noted the appearance of three moist lesions on the margin of the prepuce. He had had sexual contact about one month prior to the appearance of the coronal lesion, but denied homosexual activity.

Physical examination revealed a temperature of 99.6° F, marked tenderness of the liver with slight hepatomegaly, a maculopapular skin eruption of the chest and arms, an indurated non-tender lesion involving the corona of the glans penis and three mucous patches on the margin of the prepuce. The anal canal and rectum were normal, but the inguinal lymph nodes were enlarged bilaterally.

Laboratory data showed a normal CBC and urinalysis. The RPR was reactive and the VDRL was positive to a dilution of 1:128. The FTA absorption test showed a 4+ positive reactivity and a dark field examination of exudate from a mucous patch of the prepuce disclosed spirochetes typical of *Treponema pallidum*. Viral hepatitis A and B serologic markers

were absent. Liver function tests (LFT) are shown in Table I.

A percutaneous liver biopsy showed mild scattered hepatocyte necrosis, portal tract infiltration with many neutrophils and moderate numbers of lymphocytes and mild reticuloendothelial cell hyperplasia (Figure 1). Dieterle silver stain for spirochetes was negative.

Benzathine penicillin G was administered on March 17, 1981, and resulted in disappearance of anorexia, nausea, abdominal pain and fever during the next few days. One week after hospital discharge, the chancre had healed, the mucous patches were rapidly resolving, the enlarged, tender liver had subsided, and hepatic biochemical improvement was found; two months later all LFT were normal (see Table I).

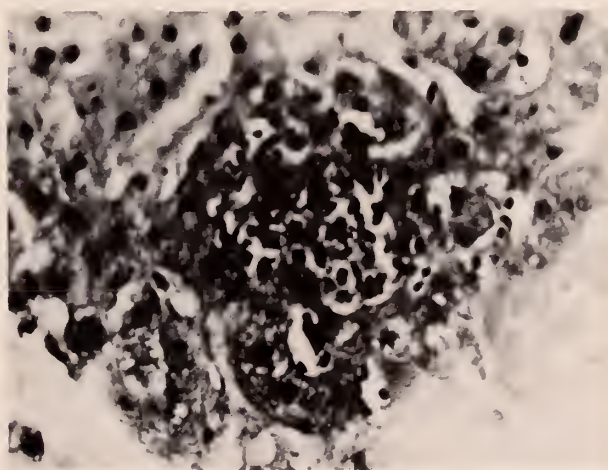


Figure 1. Liver biopsy specimen showing mild hepatocyte necrosis and portal tract infiltration with neutrophils and lymphocytes (hematoxylin-eosin, original magnification $\times 400$).

From The Field Clinic, Centreville, Mississippi.

TABLE 1
LIVER FUNCTION TESTS

Test	Normal	3/17/81	3/19/81	3/27/81	5/25/81
Total serum bilirubin	<1.5mg/dl	2.2	1.2	0.72	0.61
Alkaline phosphatase	2.5-9.7 mg/dl	91.9	62.8	31	8.2
Serum glutamic oxaloacetic transaminase (SGOT)	8-33 iu/dl	213	97	51	30
Serum glutamic pyruvic transaminase (SGPT)	3-36 iu/dl	187	65	45	27
Gamma-glutamyl transpeptidase (GGTP)	15-85 iu/dl	308	120	96	71

Discussion

Hepatic dysfunction is not commonly recognized in the primary and secondary stages of syphilis^{1, 3} although liver disease is common in congenital syphilis and may be observed in late syphilis as fibrosis, gummas and hepar lobatum.² The occurrence of liver disease in early syphilis has been the subject of considerable speculation and uncertainty in the past⁵ and the association of acute hepatitis with secondary syphilis has not been well documented.^{2, 5}

The co-existence of liver disease and early syphilis may be explained in several ways: (1) hepatic dysfunction resulting from therapeutic agents used in treating syphilis (Jarisch-Herxheimer reaction), (2) biologic false positive serologic tests for syphilis and abnormal liver function tests (collagen vascular diseases, intravenous drug use), (3) coincidental occurrence of syphilis with other types of liver disease (viral or alcoholic hepatitis) or (4) the acute hepatitis of early syphilis. This latter entity should be suggested by: (1) presence of acute liver disease in a patient with positive tests for syphilis, (2) mild elevation of serum bilirubin, SGOT and SGPT, (3) marked disproportionate elevation of serum alkaline phosphatase with moderate elevation of GGTP, and (4) prompt clinical and biochemical recovery with penicillin therapy.

If liver biopsy is done, focal hepatocyte necrosis, portal tract infiltration with neutrophils and lymphocytes, reticuloendothelial cell hyperplasia and inflammation of the central vein with fibrosis of its wall are often found. However, the histologic abnormalities may be nonspecific and rarely the biopsy specimen shows no morphologic changes.

The mechanism of liver injury in hepatitis of early syphilis is unknown, but in some cases it appears to

be related to direct invasion of the hepatic parenchyma by the *Treponema pallidum*.⁶ Autoimmune antibodies and other manifestations of immune complex disease have been found in early syphilis and the presence of these may implicate immune mechanisms in the pathogenesis of syphilitic hepatitis.⁷

The occurrence of acute hepatitis in early syphilis is unusual, but it is probably more common than is generally recognized. It is especially important to be aware of this association because of the increasing incidence of early syphilis and the ability of penicillin to rapidly reverse liver disease in syphilitic hepatitis.

Summary

A patient with acute hepatitis of secondary syphilis is reported. This unusual manifestation of early syphilis may present diagnostic difficulties resulting in a delay of appropriate therapy. Mild hepatic dysfunction with a disproportionate elevation of serum alkaline phosphatase should suggest this entity and positive tests for syphilis will be confirmative. Penicillin results in rapid subsidence of liver disease.

★★★

References

1. Sobel, H. J. and Wolf, E. H.: Liver involvement in early syphilis. *Arch. Path.* 93:565-568, 1972.
2. Feher, J., Somogyi, T., Timmer, M. et al: Early syphilitic hepatitis. *Lancet* 2:896-899, 1975.
3. Campisi, D. and Whitcomb, C.: Liver disease in early syphilis. *Arch. Int. Med.* 139:365-366, 1979.
4. Sherlock, S.: *Diseases of the Liver and Biliary System*, Ed. 6. Oxford, England: Blackwell Scientific Publications, 1981, p. 437.
5. The liver in secondary (early) syphilis, Editorial. *N. Eng. J. Med.* 284:1437-1438, 1971.
6. Haburchak, D. R. and Davidson, H.: Anorectal lesions and syphilitic hepatitis. *West. J. Med.* 128:64-67, 1978.
7. Braunstein, G. D., Lewis, E. J., Galuanek, E. G. et al: The nephrotic syndrome associated with secondary syphilis. *Am. J. Med.* 48:643-648, 1970.

Coronary Angioplasty

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Jackson, Mississippi

IN 1964 DOTTER AND JUDKINS introduced a technique of transluminal angioplasty for catheter dilatation of atherosclerotic lesions of the lower extremities.¹ Primarily the technique gained acceptance in Europe. Andreas Gruntzig in Zurich, Switzerland, modified the technique and achieved significant success rates in treating peripheral atherosclerotic lesions. He modified the catheters for balloon dilatation of coronary lesions and did canine and human studies in 1976. In September 1977, he performed the first percutaneous transluminal coronary angioplasty (PTCA) procedure in the living human.² The first procedure in the United States was done in March 1978 by Richard Myler at St. Mary's Hospital in San Francisco. Pioneering efforts by Simon Stertz at the Lenox Hill Hospital in New York City and John Simpson, Stanford University, contributed to the development of the technique.³

By January 1979, at least 50 patients had been treated in this manner for coronary obstructive disease.⁴ In June 1979, a workshop on Transluminal Coronary Angioplasty was conducted by the National Institutes of Health (NIH) and plans were developed for a registry for patients undergoing angioplasty.⁵ By early 1981 more than 1600 procedures had been done world-wide.

Technique

The technique as developed by Gruntzig involves the use of a two catheter system.⁴ A guiding catheter similar to a conventional coronary angiographic catheter is positioned in the right or left coronary ostium and a dilating (balloon) catheter is introduced through the guiding catheter and passed into the coronary artery. The dilating catheter is constructed with a small balloon for dilatation near the tip. Several balloon sizes are available, but a typical catheter has a balloon that is 3 mm in diameter and

The authors present the historical development and technique for percutaneous transluminal coronary angioplasty (PTCA) and review the current world-wide experience. Clinical indications are discussed and illustrative cases are presented showing improvement in coronary obstructive lesions using PTCA.

20 mm in length when inflated. A small port is present for monitoring pressures distal to the balloon.

After positioning the balloon across the stenotic lesion, the balloon is inflated with a controlled pressure device. Following several dilatations of the lesion, the distal pressure characteristically shows a rise above its pre-dilatation value. A reduction of the gradient across the lesion to 10-20 mmHg is hemodynamic evidence of significant dilatation. The dilating catheter is withdrawn and the guiding catheter is used for post-dilatation angiography to determine improvement.

Aspirin, dipyridamole and nifedipine are begun one day before the procedure. Nitrates are continued for at least 48 hours after angioplasty. Anti-coagulation with heparin is achieved during angioplasty. Low molecular weight dextran is infused and intravenous and intracoronary nitroglycerin are administered.

After the procedure serial electrocardiograms and enzymes are obtained. Non-invasive nuclear cardiac studies (exercise thallium-201 scan and exercise left ventricular ejection fraction) are obtained 2-3 days post-angioplasty. These studies may be repeated in 3 or 6 months and repeat coronary angiography is recommended within 6-12 months.

From the Cardiovascular Laboratories, Mississippi Heart Institute, St. Dominic-Jackson Memorial Hospital, Jackson, MS.

TABLE I
CORONARY ANGIOPLASTY⁶

<i>Series</i>	<i>Total Attempts</i>	<i>Lesions Crossed</i>	<i>Primary Success</i>	<i>Emergency Coronary Bypass</i>	<i>Restenosis</i>	<i>Deaths</i>
Gruntzig	256	215	200	23	43	0
Myler	184	145	122	8	12	0
Stertzer	172	122	109	5	28	1
NIH	66	51	43	3	7	0
France	107	79	71	8	6	0
Brazil	46	31	25	3	4	0
Netherlands	27	25	23	1	—	0
Total	858	78%	69%	6%	12%	0.1%

Current Experience

By early 1981 more than 800 patients had been entered into the NIH Registry. Of these, approximately 60% achieved primary success with the procedure. Table I summarizes data available February 1981.⁶ Procedures performed by Gruntzig, Mylar, and Stertzer are summarized. Data is also summarized from the local experience of NIH and from collected data from France, Brazil and the Netherlands.

Of those patients in whom the technique is attempted, the stenotic lesion can be crossed with the dilating catheter in about 78% of cases. Approximately 69% of the cases respond initially to balloon dilatation with good opening of the stenotic area (primary success). The incident of emergency coronary bypass surgery for sudden closure of the vessel is about 6%. The incidence of re-stenosis in patients with primary success is uncertain at this time because of the short length of follow-up but may be approximately 12% at about 6 months. Deaths directly related to the procedure have been very rare. The incidence is comparable to that occurring after coronary bypass surgery.

Clinical Application

Candidates selected for coronary angioplasty are those who have proximal coronary stenosis with recent onset of angina of sufficient severity to compromise the quality of life despite medication. The ideal lesion is one which is subtotal, noncalcified, and concentric. Also, patients who develop anginal symptoms after bypass surgery from a stenotic lesion involving the bypass graft may be candidates. Because of the potential complication of vessel closure the patient must otherwise be a candidate for coronary artery bypass and surgical stand-by is

TABLE II
SELECTION FOR CORONARY ANGIOPLASTY

1. Recent Onset of Angina
2. Compromised Quality of Life Despite Medical Therapy
3. Proximal Coronary Stenosis
4. Otherwise a Candidate for Coronary Bypass Surgery

arranged. At this time left main coronary stenosis is considered a contraindication. Relative contraindications include a longer history of angina pectoris, tortuosity of the involved artery and calcification of the lesion. Table II summarizes patient selection criteria.

Illustrative Cases

A 70-year-old woman began to have typical exertional angina four months previously. Three months prior to admission she had an anterior subendocardial infarction. Because of disabling angina, cardiac catheterization was done and demonstrated excellent wall motion on left ventriculogram and an elevated end diastolic pressure of 20 mmHg. There was a 95% concentric stenosis in the anterior descending coronary artery below the first septal branch. There were lesions of minor significance in the right coronary artery and left circumflex arteries. Thallium exercise myocardial scan revealed a perfusion defect in the upper septum and anterior wall of the left ventricle. Figure 1A and 1B depict the left anterior descending coronary artery in the right oblique view before and after angioplasty. The patient is now free of angina and there is marked improvement in the exercise thallium myocardial scan.



Figure 1A



Figure 1B



Figure 2A



Figure 2B



Figure 3A



Figure 3B

This 61-year-old man had coronary bypass surgery with a graft into the left anterior descending coronary artery in 1974. He was free of angina until six months prior to a recent cardiac catheterization which revealed the vein graft to the left anterior

descending to be patent, but there was a lesion of 75% obstruction in the left circumflex coronary artery which had not been present at the pre-operative catheterization in 1974. Figures 2A and 2B are of the left coronary in the right oblique view.

The left circumflex lesion shows moderate improvement after angioplasty. His angina is markedly improved.

This 54-year-old man sustained an inferior myocardial infarction about five months previously and continued to experience angina pectoris. Cardiac catheterization revealed a high grade lesion in the right coronary artery, a normal left coronary system and essentially normal left ventricular function. Exercise electrocardiogram was positive with an inferior ischemic defect on exercise thallium 201 myocardial scan. After an initial unsuccessful attempt to dilate the lesion with a 3 mm balloon, the patient returned and dilatation was accomplished with a 3.7 balloon. Figures 3 A and 3 B depict the right coronary artery in the right oblique view before and after angioplasty. Post-dilatation exercise test and thallium scan were improved and he is free of angina.

Conclusion

At the present time coronary angioplasty is applicable to a select group of patients with coronary disease, specifically those with recent onset angina, proximal coronary stenosis and post-bypass patients with isolated vein graft stenosis. Successful dilatation may be obtained in over 70% of cases attempt-

ed. Further improvement in catheter design will probably increase the percentage of stenotic lesions that can be crossed and dilated with the balloon catheter. Long term patency rates are to be determined, but of those lesions which remain dilated at 6 months, most show continued patency at greater than two years. Coronary angioplasty offers an alternative to bypass surgery for selected patients and increases the options available in treating atherosclerotic heart disease. ★★★

971 Lakeland Drive (39216)

References

1. Dotter, C. T. and Judkins, M. P.: Transluminal Treatment of Arteriosclerotic Obstruction. *Circulation* 30:654-670, November 1964.
2. Gruntzig, A.: Transluminal Dilatation of Coronary-Artery Stenosis. *Lancet* 1:263, February 4, 1978.
3. Stertzer, S. H., Myler, R. K., Bruno, M. S. and Wallsh, E.: Transluminal Coronary Artery Dilatation. *Pract. Card.* 5:25-32, March 1979.
4. Gruntzig, A., Senning, A., and Siegenthaler, W.: Nonoperative Dilatation of Coronary-Artery Stenosis. *N. Eng. J. Med.* 301:61-68, July 12, 1979.
5. Levy, R., Jesse, M., and Mock, M.: Position of Percutaneous Transluminal Coronary Angioplasty (PTCA). *Circulation* 59:613, 1979.
6. Data presented at Demonstration in Percutaneous Transluminal Coronary Angiography, Emory University, Atlanta, Ga., February 1-5, 1981.

Genital Herpes

THOMAS J. BROOKS, JR., M.D.*
Jackson, Mississippi

- I. *Infectious Agent*: Type 2 or less commonly, Type 1 herpes simplex virus.
- II. *Clinical Characteristics*: Five herpes viruses are known to infect humans. They are:
 - 1, 2. Herpes simplex viruses Type 1 and 2.
 3. Cytomegalovirus, producing
 - A. Congenital cytomegalovirus infection
 - B. Cytomegalic inclusion disease
 - C. Cytomegalic mononucleosis
 4. Varicella-Zoster virus, producing
 - A. Chicken pox
 - B. Shingles
 5. Epstein-Barr virus, producing
 - A. Infectious mononucleosis
 - B. Burkitt's lymphoma, in Africa
 - C. Nasopharyngeal cancer, in Southeast Asia
 - D. May be associated with Hodgkin's disease
(30%-40% of patients have antibody to EBV but the prevalence of antibody in the general population is unknown)

Herpes simplex Type 2: Usually sexually transmitted. Very prone to become latent. Infected persons may shed the virus in absence of clinical manifestations. Most herpes simplex meningitis is due to Type 2. Can be acquired by fetus in birth canal. In adults the majority of lesions are "below the waist" but they can occur anywhere on the body.

Though first described in 1971, genital herpes has become almost epidemic in some locations. In Boston the incidence has been reported to be seven times that of syphilis.¹ Interest in this virus relates primarily to its association with cancer of the cervix uteri.²⁻⁸ In one study, women with HSV-2 infection

were five times more likely to develop cervical cancer.² Some cautious observers maintain, however, that a true etiologic relationship has not been proven.

Herpes simplex Type 1: Though this herpes virus is usually found "above the waist" (cold sores, fever blisters) 20% to 40% of genital herpes are due to HSV-1, where the clinical findings are similar to the above.

- III. *Diagnosis*: By demonstration of characteristic lesions on cervix or vulva in the female or on external genitalia of male, and by demonstration of intranuclear inclusion bodies plus direct immunofluorescence tests.
- IV. *Occurrence*: Worldwide. HSV-1 usually acquired in childhood; HSV-2 during adolescence or later.
- V. *Reservoir Hosts*: Infects only humans.
- VI. *Mode of Transmission*: HSV-1 usually by contact with infected saliva. HSV-2 usually by sexual contact.
- VII. *Incubation Period*: Several days to 2 weeks.
- VIII. *Communicability*: Varies. Latent infections may become communicable at any time, with or without symptoms.
- IX. *Treatment*: Certain purine and pyrimidine nucleoside analogues, notably acyclovir, have shown considerable promise experimentally. Acyclovir is now available for general use, but its effectiveness remains in question in the majority of cases.
- X. *Prevention*: Good personal hygiene plus avoidance of intimate contact with infected person.
- XI. *Reporting Requirements*: Weekly reports to county health department.
- XII. *References*:
 1. (Editorial): Genital Herpes. Brit. Med. J. p. 1335-1336, June 7, 1980.
 2. Burt, J. L.: The epidemiology of genital herpes (HSV-2) infection. Royal Soc. Health J. 1:31, 1979.
 3. (Editorial): Genital herpes and cervical carcinoma. Brit. Med. J. 1(616):807, April, 1978.
 4. Smith, J. W. et al: Association of herpes simplex virus (HSV) with cervical cancer by lymphocyte reactivity with HSV-1 and HSV-2 antigens. Am. J. Epidem. 110(2):141-147.
 5. Choi, N. W. et al: Herpes virus infection and cervical anaplasia — a seroepidemiological study. Int. J. Cancer 19:167-171, 1977.
 6. Ito, Hisao, et al: Serum antibodies to herpes virus early antigens in patients with cervical carcinoma determined by anticomplement immunofluorescence technique. Int. J. Cancer 18:557-563, 1976.
 7. Figueroa, Manuel and Rapp, F.: Herpes viruses and human cancer. Bul. Pan. Am. Health Org., 14(3):269-279, 1980.
 8. Nahmias, A. J. et al.: The Human Herpes Viruses. New York: Elsevier, 1980.

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Radiological Seminar CCXXII: Bilateral Diffuse Pulmonary ⁶⁷Ga Uptake

DOROTHY S. LIN, M.D.

Jackson, Mississippi

BILATERAL DIFFUSE PULMONARY UPTAKE, a phenomenon which is not well understood, is occasionally seen during radiogallium imaging either for primary pulmonary disease or in the search for occult disease.

Case Report

A 38-year-old black female had limited intraductal carcinoma of the left breast that was discovered in 1976. All followup examinations were negative until May 1981, at which time a chest radiograph showed probable lymphangitic spread of metastatic carcinoma (see Figure 1). Ten days later, ⁶⁷Ga images were obtained which showed diffuse intense increased activity in both lung fields and increased uptake in the mid-mediastinal nodal area (see Figure 2). Fiberoptic bronchoscopy with transbronchial biopsy was performed twice, all showing noncaseating granulomas with negative stains for AFB and fungi. The patient had a negative PPD. She was diagnosed as having sarcoidosis and was discharged on Prednisone 1 mg/kg/day. After two months of treatment there was improvement in the increased interstitial markings on the chest radiograph and modestly decreased intensity of the uptake in both lungs (not shown) when compared to the first set of ⁶⁷Ga images.

When interpreting this very striking but rather nonspecific finding of bilateral diffuse pulmonary uptake of ⁶⁷Ga, it is essential to review the possible causes for proper diagnosis. A gamut of the known causes organized according to their prevalence is shown as follows:

Common

Bacterial or viral pneumonia¹
Pneumocystis carinii infection¹
Interstitial pneumonitis¹
Sarcoidosis¹
Active tuberculosis — miliary,² progressive primary,³ disseminated⁴
Chemotherapeutic drug-induced pneumonitis^{1, 3, 5}
— hydroxurea, busulphan, bleomycin, cyclophosphamide, nitrosoureas
Interstitial inflammatory reaction — addictive drug abuse⁵
Pneumoconiosis¹ — silicosis, asbestosis

Uncommon

Diffuse lymphoma¹ — Hodgkin's, non-Hodgkin's
Bronchitis¹
Diffuse lung metastases,⁶ lymphangitic carcinomatosis³
Following contrast lymphangiography⁷
Idiopathic pulmonary fibrosis^{1, 3, 4}
Radiation pneumonitis¹
Uremic pneumonia⁵

Rare

Leukemia¹
Disseminated lupus erythematosus⁴
Septic micro emboli⁴
Angioimmunoblastic lymphadenopathy⁸
Bilateral pleural effusion⁶
Multiple myeloma¹
Hamman-Rich syndrome¹

Since radiogallium concentrates in the very early stage of diseases, diffuse pulmonary uptake has been reported quite often when no appreciable chest radiographic changes could yet be recognized.^{3, 9, 10} In these cases, awareness of this finding and identification of its etiology are essential for

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, University of Mississippi
Medical Center, Jackson, MS



Figure 1. PA chest radiograph showing bilateral prominent hilar nodes and diffuse interstitial coarsening in both lungs.

early treatment. Listed below is a gamut of bilateral diffuse pulmonary ^{67}Ga uptake with possible normal chest radiographs:

Common

Pneumocystis carinii³
After multiple cycles of chemotherapy^{3, 9}
Drug addiction⁹
Early tuberculosis¹⁰

Uncommon

Sarcoidosis³
Early pneumoconiosis¹⁰
Early lymphoma⁹
Following contrast lymphangiography⁷

Acknowledgment

The author wishes to thank Linda T. Prior for her editorial assistance in preparing this manuscript.

2500 North State Street (39216)

References

1. Gupta, S. M., Sziklas, J. J., Spencer, R. P. and Rosenberg, R.: Significance of diffuse pulmonary uptake in radiogal-



Figure 2. 72 hr ^{67}Ga images showing diffuse homogeneous uptake in both lungs of 4+ intensity (pulmonary activity concentration greater than that of the liver). Increased uptake in the mediastinal nodes is seen while both hili are obscured.

- lium scans: Concise communication. J. Nucl. Med. 21:328-332, 1980.
2. Winzelberg, G. G.: Radionuclide evaluation of miliary tuberculosis. Cl. Nucl. Med. 6:330-331, 1981.
3. Siegel, B. A. (ed.): *Nuclear Radiology (Second Series) Syllabus*. Chicago, ACR, 1978, 360-373.
4. Siemsen, J. K., Grebe, S. F. and Waxman, A. D.: The use of gallium-67 in pulmonary disorder. Semin. Nucl. Med. 8:235-249, 1978.
5. Kim, E. E.: Diffuse pulmonary gallium concentration. Semin. Nucl. Med. 10:108-109, 1980.
6. Kubo, A., Takagi, Y., Ando, Y. and Hashimoto, S.: Analysis of diffuse gallium lung uptake. (abstr.) J. Nucl. Med. 20:674-675, 1979.
7. Lentle, B. C., Castor, W. R., Khaliq, A. and Dierich, H.: The effect of contrast lymphangiography on localization of ^{67}Ga -citrate. J. Nucl. Med. 16:374-376, 1975.
8. Patel, A. R. Shah, P. C., Sirpal, S. C. and Dulay, C. C.: ^{67}Ga uptake in angioimmunoblastic lymphadenopathy. Cl. Nucl. Med. 2:368-369, 1977.
9. MacMahon, H. and Bekerman, C.: The diagnostic significance of gallium lung uptake in patients with normal chest radiographs. Radiology 127:189-193, 1978.
10. Siemsen, J. K., Sargent, E. N., Grebe, S. F., Winsor, D. W., Wentz, D. and Jacobson, G.: Pulmonary concentration of Ga^{67} in pneumoconiosis. Am. J. Roentgenol. 120:815-820, 1974.



The President Speaking

MSMA Speaks at the AMA

SIDNEY O. GRAVES, JR., M.D.
Natchez, Mississippi

The annual meeting of the American Medical Association was held in Chicago, June 13-17. There was good representation from both our state association and the Auxiliary.

This is a no-nonsense, working meeting where many subjects and issues are presented, debated and either accepted or rejected. The different delegations are well prepared. Most of them are acquainted with their subject matter and amply prepared to discuss all phases of an issue.

Rather than trying to discuss all the highlights of the meeting in this brief space, I should like to confine my remarks to the outcome of one resolution about which we all have reason to be proud.

This particular resolution was authored by Dr. Lamar Weems and presented by our delegates to the AMA, Dr. Weems and Dr. James O. Gilmore. It recommended that graduates of medical schools not accredited by the Liaison Committee on Medical Education (and that would be all foreign schools except Canadian schools) be required to provide documentation that their training institution was equal in quality to an LCME-accredited school. The AMA Council on Medical Education opposed the resolution recommending instead that all applicants for licensure have at least one year of an accredited program of graduate medical education in the United States. The Reference Committee which considered the Council's recommendation and the Mississippi resolution urged that the former be approved and the latter not be adopted.

When the Reference Committee report was presented to the House of Delegates, Dr. Weems assumed the role of Giant Killer. He pointed out among other things that the Council on Medical Education recommendation implied "... that the medical school experience is dispensable. . . ." His persuasive argument carried the day and the Mississippi resolution passed over what began as overwhelming opposition.

Perhaps even as meaningful as its passage, the Mississippi resolution demonstrated that a relatively small, two-delegate state can be heard in the AMA House of Delegates.

There are only a fortunate few doctors in our state who have attended a business session of the AMA. It's a shame that more don't attend. It might just change your opinion of what the AMA does for all of us.

Fragile Ecology Imposes Limitations

Those of our readers who are ecology minded will be interested in reading about Nepal, a primitive country with a very fragile ecology, whose greatest claim to fame is the fact that it contains three of the world's great mountain peaks, the most famous of which is Mt. Everest. Were it not for this, its very remoteness and its limited resources would probably insure very little change over the years.

Dr. Thomas B. Pace of Monticello, Mississippi, one of our young graduates from University Medical Center, recently participated in a medical survey as a member of a team sponsored by the Johns Hopkins University Department of International Health. He describes Nepal as a small developing country nestled in the Himalaya Mountain range, surrounded on three sides by India and on the fourth by China. Its latitude is approximately that of the state of Florida, but its climate ranges from subtropical in the lower valleys to mild summers and cold winter in the higher altitudes.

The entire country is subject to monsoons from July through August. Only about 13% of the land is considered arable, and the total subsistence is from rather primitive farming. Only 5% of the population are functionally literate and modern medicine is almost non-existent. The majority of the population use home herbal remedies administered by the Jaunkri, the local "witch doctors." Birth control pills are virtually unheard of. Seventy percent of deaths are under age 15, and there are no appreciable sanitation measures. More impressive to me than any of these important points is the fragile ecology.

A few years ago a concerted and successful effort was made to eradicate malaria from the lower regions. As a result, more and more people are moving in; and as the great forests are cleared to accommodate them, erosion from the monsoon rains has quickly followed. In the higher altitudes, where the ecology is even more fragile, the steady influx of

climbers and trekkers further depletes the sparsely wooded areas of the only fuel supply, and erosion continues to increase.

As we try to help developing nations, I believe our first consideration and responsibility should be to educate them to limit their populations to the supportive capacity of the land. Indeed this applies to all nations. Even ours approaches a limit.

W. MONCURE DABNEY, M.D.
Editor

The Mississippi State Medical Association is grateful to the following companies for their financial support of the recent 114th Annual Session.

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On August 1, 1982, the new corporate name of the Mississippi Medical Fraternal and Educational Society, Inc., will officially become The Medical Assurance Company of Mississippi, Inc. The Organizational structure, philosophy, and dedication to serve the physicians of Mississippi will remain exactly the same as when MMFES wrote its first policy in November, 1977. The Medical Assurance Company, as was MMFES, is a non-

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MEDICAL ORGANIZATION

Ob-Gyn Alumni Meet in Jackson



Seventy-eight physicians met at the University of Mississippi Medical Center for the annual UMC ob-gyn alumni meeting. From left are outgoing president Dr. H. Lamar Gillespie of Hattiesburg; Dr. E. J. Price, Jr., of McComb, president; Dr. G. Rodney Meeks, UMC assistant professor of ob-gyn, secretary-treasurer; Dr. Jack C. Hoover of Pascagoula, member of the board of directors; and Dr. Winfred Wiser, chairman of the UMC Department of Obstetrics and Gynecology. Not pictured is Dr. Joe Hester of Muskogee, Oklahoma, who is vice-president elect.

Dr. Richard Hollis Named Physician of the Year

Dr. Richard S. Hollis was recently named Physician of the Year by the American Association of Medical Assistants, Mississippi Society.

The Amory obstetrician practices at the Physicians and Surgeons Clinic, in association with Drs. John Seay, Melvin Holman and Leonard Pinckley.

A native of Amory, he received the B.S. degree from Mississippi State University and the M.D. degree from Tulane University School of Medicine. He interned and completed a residency in obstetrics and gynecology at Charity Hospital in New Orleans.

He is a diplomate of the American Board of Obstetrics and Gynecology and a fellow of the American College of Obstetricians and Gynecologists. A fellow of the American College of Surgeons, Dr. Hollis has served as vice-chairman of the Mississippi Chapter. He has served as vice-president and

president of the Mississippi Ob-Gyn Society, chairman of the Sub-Area Council of the Mississippi Health Systems Agency, and president of the Northeast Mississippi Medical Society. In 1975 Dr. Hollis was a representative to the President's Forum on Domestic Policy.

Dr. Hollis considers the AAMA an important organization and an asset to local communities. He has stated, "It's very educational and is designed to increase the knowledge and capabilities of doctors' employees, which in turn improves the quality of the medical care available to the patient."

Dr. Hollis has been a part of the medical community in Amory for 22 years, having founded the clinic in 1960. He has delivered between 5,000 and 6,000 babies, and considers it a "great feeling" to be a part of the continuity of the community.

146 Receive M.D. Degrees During UMC Commencement

Hilton Lamar Gillespie, Jr., of Hattiesburg was recognized as the top medical school graduate in University of Mississippi Medical Center Commencement ceremonies in Jackson May 30.

Dr. Gillespie, who earned his degree summa cum laude, received the University's Leathers Award as the graduating medical student with the highest academic average. Son of Dr. and Mrs. H. L. Gillespie of Hattiesburg, Dr. Gillespie will intern at the University of Alabama Medical Center in Birmingham. He earned the B.S. at the University of Southern Mississippi in 1978.

Former Lt. Governor Evelyn Gandy, now deputy for human resources in the Department of Mental Health, was Commencement speaker. She praised the Medical Center's contributions to Mississippi — pointing out that the 1982 graduates will bring the total number of health professionals trained there to more than 5000 — and challenged the graduates to constantly study, reason, inquire and strive for the impossible.

"Untold millions of people have enjoyed a better way of life," she said, "governments have been established and strengthened, civilization has progressed and is being refined by the achievements of

men and women willing to go beyond their normal service and reach for the full potential of their abilities. . . ."

Degree recipients included 146 for the M.D. degree; 93 for the B.S. in nursing; 19 for the Ph.D., the M.S. and the master of nursing; and 31 for the D.M.D.

Graduates also included 13 for the B.S. in medical record administration; 10 for the B.S. in medical technology; 11 for the B.S. in nurse anesthesiology; and 27 for the B.S. in physical therapy.

Other honor graduates in the School of Medicine were Kent Calhoun Keys of Hattiesburg, Sherry Ann Alcorn of Hattiesburg and John Russell Wooley of Jackson who earned the M.D. magna cum laude. Cum laude graduates in medicine were William Earnest Tew of Laurel, Philip Coleman Dean of Long Beach, Leonard Alan Johnson of Tupelo, Ralph Wayne Smith of Pearl, William Stewart Lawrence of Belzoni and Patricia Lynn Dudley of Meridian.



Hilton Lamar Gillespie, Jr., of Hattiesburg, center, was recognized as the top medical school graduate in University of Mississippi Medical Center commencement ceremonies. At right is University of Mississippi chancellor Dr. Porter L. Fortune, and at left is vice-chancellor and medical school dean Dr. Norman A. Nelson.



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RECOLLECTIONS

Twenty years ago, the July 1962 issue of JOURNAL MSMA reported that 62 had received the M.D. degree at the sixth annual commencement of the University of Mississippi School of Medicine. Advanced degrees in health sciences were awarded to five candidates, and 13 women received B.S. degrees in nursing. Of the M.D. recipients, 58 were Mississippians.

A news article described a report in the AMA-published *Today's Health* magazine which estimated that one out of every 15 teenagers was likely to become an alcoholic. An authority on the subject, Dr. Marvin A. Block of Buffalo, New York, predicted that without broadening educational programs and without taking greater action to produce more understanding of the subject of alcoholism, about 6% of the nation's teenagers would become alcoholics.

The 1962 issue reported that the Mississippi State Board of Health had begun organization of a phenylketonuria detection program. Dr. Frank M. Wiygul of the Maternal and Child Health Division described the program in the article, which also noted that MSMA's House of Delegates had taken action to urge the development of such a program.

The Mississippi State Board of Health also made news as recipient of a National Auto Safety Honor Award in recognition of outstanding accident prevention activities during 1961.

It was reported that health insurance benefit payments by insurance companies during the first three months of 1962 totaled \$947 million, and that in 1961 health insurance benefit payments by insurance companies averaged \$9.5 million a day.

Scientific articles included "Errors and Complications in the Management of Small Intestinal Obstruction," by William O. Barnett, M.D., of Jackson; "Maternal Mortality in Mississippi During 1959," by Michael Newton, M.D. of Jackson; and "Pharyngo-esophageal Diverticulum," by Albert J. McIlwain, M.D. of Jackson.

Are the results of
\$100 million worth of
government-funded research
on hypertension
worth reading about?



POSTGRADUATE CALENDAR

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August 21-22, 1982

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These programs are sponsored by the University of Mississippi School of Medicine and the Medical Center Division of Continuing Health Professional Education. For more information, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone: (601) 987-4914.

MEDICO-LEGAL BRIEF

Qualified Privilege

Applied To Staff Meetings

A chief-anesthetist was not liable to a staff-anesthetist for defamation because his discussions about the staff-anesthetist in staff meetings and with consultants were subject to a qualified privilege, the Mississippi Supreme Court ruled.

The defamation case was based on two incidents. The staff-anesthetist was disappointed in the selection of the chief anesthetist and resented his promotion. The chief-anesthetist accused him of charging the hospital for overtime that had not been worked and of stealing. The chief prepared new guidelines for the staff to follow in administering anesthesia and he revised the department handbook and work schedules. The staff-anesthetist refused to comply with the guidelines and policies, and the personal relationship between the two deteriorated. The staff-anesthetist employed an attorney and requested a meeting with the hospital administrator. Two meet-

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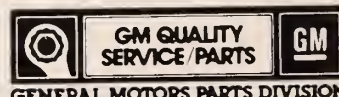
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ings were held with various hospital officials present.

The second incident involved the staff-anesthetist's treatment of three patients. The chief charged him with failing to properly administer anesthesia to a patient in the operating room so that the patient experienced great pain during surgery; an elderly patient admitted for a follow-up operation refused to let the staff-anesthetist administer anesthesia to her because he failed to put her to sleep during her first operation; and because he failed to properly monitor the fluid levels of a critically ill patient, the patient went into respiratory failure and had to be resuscitated. The staff-anesthetist was presented with the charges and was told that he would be terminated if the charges were supported. He then resigned and later filed suit for defamation and actionable words. A trial court awarded him \$500,000, which was reduced to \$75,000.

On appeal, the Supreme Court said that a qualified privilege was in effect at all times that the allegedly defamatory matters were discussed. All persons

present in hospital staff meetings and those consulted by the chief-anesthetist were directly interested in the case and a qualified privilege existed for the discussions, the court said. The statements were made in good faith and without malice. It was the duty of the chief-anesthetist to report any matters which he considered in violation of rules and guidelines of his department. His reports to his superiors that were critical of the staff-anesthetist's performance were made in good faith and without malice, the court said.

The judgment for the staff-anesthetist should be reversed, the court concluded. — 407 So.2d 535 (Miss.Sup.Ct., Dec. 2, 1981; rehearing denied, Jan. 6, 1982)

JOURNAL MSMA encourages your participation. Comments, inquiries and suggestions are invited.

**In 1977, when
the Veterans Administration
compared Step-2
regimens in 450 mild
hypertensive patients,
which regimen was
proven most effective?'**



MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 19-23, 1983, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610

State and Local

Mississippi State Medical Association, 115th Annual Session, May 11-15, 1983, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, July 6-9, 1983, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39221.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 3rd Wednesday, January, May, and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. J. Barry Gilbert, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Robert L. Coggin, Pres. and Secy., 965 Aven Dr., Grenada 38901. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, State, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March,

June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Albert H. Laws, Secy., 816 Second Ave. North, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, June, September, December. Robert D. Holbert, Secy., P.O. Box 1502, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Douglas F. Thomas, Secy., 415 South 28th Ave., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

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Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Biloxi Regional Medical Center
1559 Lafayette St
Biloxi, MS 39533

Mississippi Radiological Society
316 Medical Arts Building
Jackson, MS 39201

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

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American College of Surgeons
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Mercy Regional Medical Center
100 McAuley Drive
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North Panola County Hospital
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A Message from the Mississippi State Pharmaceutical Association

TEAMWORK IN FIGHTING DRUG ABUSE

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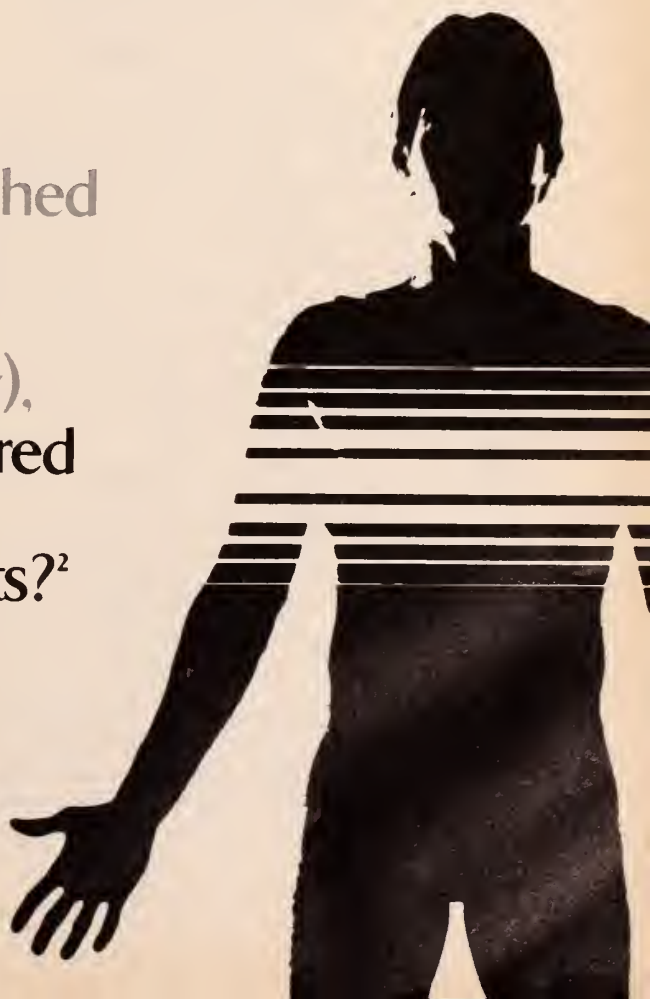
The physician and the pharmacist are "symbiotic" teammates in the fight against drug abuse. In recent years, pharmacists have been hyper-cautious in dispensing prescriptions for Rx drugs which lend themselves to abuse. In this connection, the authorities — with the help of pharmacists — have caught many drug abusers who had written prescriptions on Rx blanks stolen from physicians. And that's why a pharmacist might phone you to verify whether or not you had actually prescribed a drug for a patient he or she does not know.

To sum up: Fighting drug abuse is just another example of physician-pharmacist teamwork — a voluntary interprofessional effort designed to promote the legitimate use of legitimate drug products.

Interprofessionally yours,

Pharmacists of Mississippi

In 1979, when results were published for the five-year, 10,000-patient Hypertension Detection and Follow-up Program (HDFP study), which Step-2 regimen was preferred and was deemed effective without significant adverse effects?²



Review A Book

The following books have been received. Medical readers (members of MSMA) interested in reviewing any of these volumes should address their requests to Editor, JOURNAL MSMA, P.O. Box 5229, Jackson, MS 39216. After submitting to the JOURNAL a review for publication, you may keep the books for your personal libraries.

Something Hidden: A Biography of Wilder Penfield. By Jefferson Lewis, Garden City, New York; Doubleday & Company, 1981. \$17.95.

Physician's Handbook: Twentieth Edition. Los Altos: Lange Medical Publications, 1982. \$12.00.

Manual of Clinical Problems in Obstetrics and Gynecology. Edited by Michel E. Rivlin, M.D., John C. Morrison, M.D., and G. William Bates, M.D. Boston; Little, Brown & Company, 1982. \$15.95.

Current Medical Diagnosis & Treatment. Edited by Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. Los Altos: Lange Medical Publications, 1982. \$26.00.

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PERSONALS

ORLANDO ANDY of UMC presented a paper at the meeting of the Society of Biological Psychiatry in Toronto in May.

WILLIAM BATES of UMC presented a paper at the recent annual meeting in Dallas of the American College of Obstetricians and Gynecologists.

L. H. BRANDON of Starkville has been recertified to membership in the American Academy of Family Physicians.

CURTIS W. CAINE of Jackson, immediate past president of the Association of American Physicians and Surgeons, spoke recently in Charleston, South Carolina, at the Second International Meeting of IAT-ROS, the umbrella international organization of physicians in private practice.

CARL EVERS of Jackson presided as president at the American Association of Medical Colleges — Southern Group on Student Affairs in St. Simons Island, Georgia, in May.

JAMES E. GRIFFIN of Jackson has been elected chairman of the Hinds County Advisory Board, Mississippi Lung Association.

JAMES HUGHES of UMC recently spoke at the Gulf Coast Community Hospital surgical staff meeting.

SAMUEL JOHNSON of UMC spoke at a recent meeting of the southeastern section of the National Rehabilitation Association in Biloxi.

E. GORDON KING announces the opening of his office for the practice of general surgery and gynecology at 163 Wilson Avenue in Monticello.

WILLIAM BATES of UMC presented a paper at the recent annual meeting in Dallas of the American College of Obstetricians and Gynecologists.

DANNY D. MOORE has joined Amory Internal Medicine Clinic (BRUCE E. ATKINSON and ROGER D. RATLIFF) for the practice of internal medicine.

HERBERT LANGFORD of UMC received the Silver Distinguished Achievement Award from the American Heart Association, Mississippi Affiliate. He is the sixth recipient in 31 years to earn the organization's most prestigious award. Dr. Langford recently spoke at a meeting of Texas Medical Association and also presented a paper at the American Society for Clinical Investigation.

JOHN C. LONGEST of Starkville has been selected by the American College Health Association as the 1982 recipient of the Ruth E. Boynton Award for distinguished service at the association's 60th meeting held recently in Seattle, Washington.

THOMAS S. MESSER has joined The Hattiesburg Clinic, P.A., 415 South 28th Avenue in Hattiesburg, for the practice of cardiology.

FRANCIS S. MORRISON of UMC recently was visiting professor at St. Elizabeth Hospital Medical Center of the Northeastern Ohio University College of Medicine in Youngstown, where he presented a symposium on hemorrhagic complications in surgery.

JOHN MORRISON of UMC recently was visiting professor at the University of Indiana, was guest speaker at the 10th annual Perinatal Medical Conference in Columbus, Georgia, and spoke at the South Central Obstetrics and Gynecology Society in Scottsdale, Arizona.

W. W. OLIPHANT of Dekalb has been recertified for membership in the American Academy of Family Physicians.

SESHADRI RAJU recently spoke to the medical staff at the North Mississippi Medical Center in Tupelo.

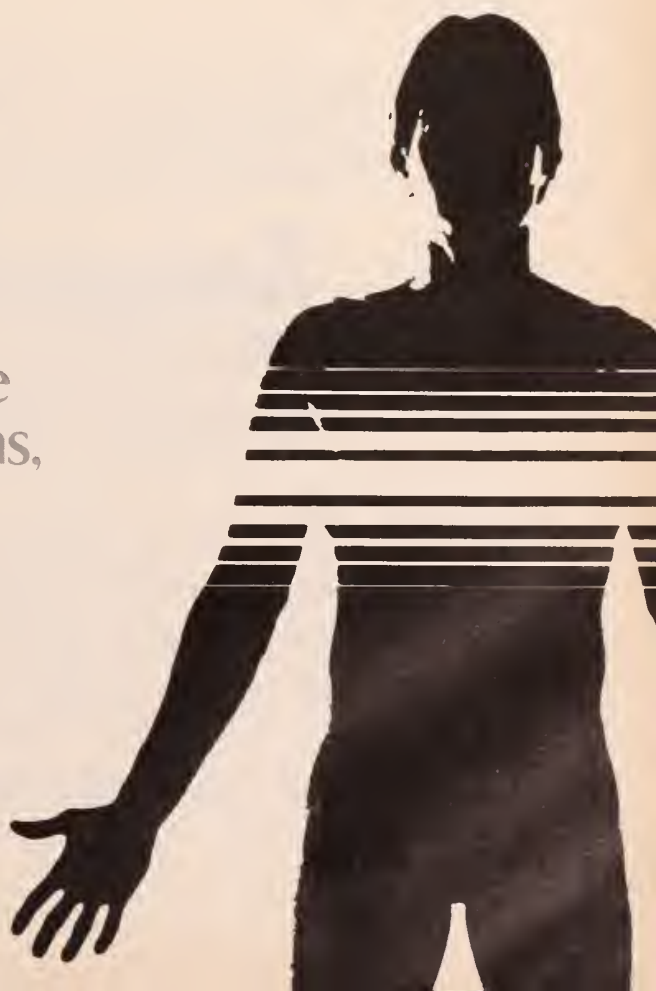
ROLAND B. ROBERTSON of Jackson has been elected president of the board of directors of the Mississippi Lung Association.

FRANCIS J. SELMAN, JR. of Ocean Springs has been appointed a member of the Mississippi Gulf Coast YMCA board of directors.

TATE THIGPEN of UMC recently presented a paper at the American Society of Clinical Oncology meeting in St. Louis, Missouri.

WINFRED WISER of UMC spoke at the annual meeting of the American College of Obstetricians and Gynecologists in Dallas.

In 1980, when the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure published their recommendations, which Step-2 regimen best met their criteria for effectiveness, safety, simplicity of titration, convenience, and economy?³





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NEW MEMBERS

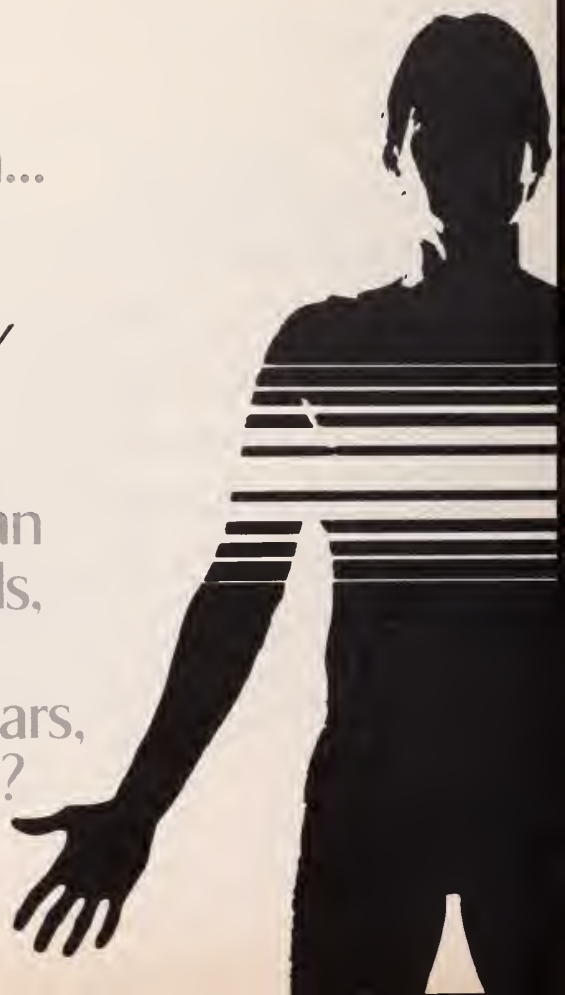
ALCALEN, ERLINDA V., Bay St. Louis. Born Manila, Philippines, April 25, 1940; M.D., College of Medicine University of the Philippines, Manila; interned Philippines General Hospital, Manila, one year; USPHS, New Orleans, Jan.-June 1976; ob-gyn residency, Philippines General Hospital, 1964-68; ob-gyn residency, USPHS New Orleans, 1976-78; elected by Coast Counties Medical Society.

BROWN, ANDREW B., Jackson. Born Hollandale, MS, Aug. 20, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned Baptist Memorial Hospital, Memphis, one year; otolaryngology residency, University Medical Center, Jackson, MS, 1978-80; otolaryngology residency, Duke University, July 1980-Dec. 1981; elected by Central Medical Society.

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COLLINS, MONICA J., Jackson. Born Montreal, Canada, June 23, 1935; M.D., University of Ottawa Faculty of Medicine, Ottawa, Ontario, Canada, 1963; interned Royal Victoria Hospital, Canada, one year; pediatric residency Montreal Children's Hospital, 1964-65, Hospital for Sick Children, Toronto, 1965-66, Montreal Children's Hospital, 1966-67, Royal Edward Chest Hospital, Montreal, 1967-68, Ottawa General Hospital, 1968-69; elected by Central Medical Society.

HARTWIG, GEOFFREY B., Hattiesburg. Born Milwaukee, WI, June 24, 1947; M.D., Duke University School of Medicine, Durham, NC, 1972; interned Duke University Medical Center, Durham, one year; neurology residency, same, 1974-76; elected by South Mississippi Medical Society.

HOWORTH, BECKETT, Jackson. Born West Point, MS, Aug. 1, 1902; M.D., Washington University School of Medicine, St. Louis, Missouri, 1925; in-

terned Presbyterian Hospital, New York, NY, 1925-27; orthopedic surgery residency, New York Orthopedic Hospital, 1927-29; orthopedic fellowship, same, 1929-33; elected by Central Medical Society.

KIRCHNER, KENT ALAN, Jackson. Born San Diego, CA, March 3, 1947; M.D., University of Virginia School of Medicine, Charlottesville, 1973; interned University of Kentucky, Lexington, one year; internal medicine residency, same, 1974-76; fellowship nephrology, same, 1976-78; residency nephrology, same, 1977-78; elected by Central Medical Society.

KUEBLER, RICHARD S., New Albany. Born Memphis, TN, April 29, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned University of Alabama, Birmingham, one year; diagnostic radiology, same, 1978-81; elected by Northeast Mississippi Medical Society.

And there's more proof on the way!

1982 will see the completion of the Multiple Risk Factor Intervention Trial (MRFIT)—a six-year, 12,000-patient study assessing the factors that increase risk of cardiovascular disease. For the management of hypertension, the preferred Step-2 regimen in this study is reserpine-thiazide.

In 1978, in a preliminary report presented to the Epidemiology Section of the American Heart Association (Dallas, Nov 1978), after 12 months of the trial, fewer patients (5.3%) treated with reserpine suffered depression than even the untreated control group (7.7%)!

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Physicians Wanted

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FAMILY PRACTITIONERS. Excellent private practice opportunity, well equipped 30-bed hospital in operation less than two years. Office space available in renovated clinic, 100-bed nursing home, nice community, good schools and recreational facilities, located 30 miles east of Jackson. Call (601) 732-6252 or write A. B. Farris, Jr., Mayor, P. O. Drawer 338, Morton, MS 39117.

Situations Wanted

HEMATOLOGIST-ONCOLOGIST seeks associate or solo practice. Contact Thomas Twele, M.D., 272 Shadow Mountain, El Paso, TX 79912.

SURGEON seeks location in general thoracic and cardiac surgery upon completion of residency in July, 1982. Graduate of Tulane University, 1975. Contact Dr. Kevin M. Keubler, 600 Highland Ave., Madison, WI 53792.

PHYSICIAN completing radiology residency in June 1982 seeks location with private community hospital. Graduate of Harvard. Contact Dr. Eugene B. Rosenberg, Mount Sinai Medical Center, 4300 Alton Road, Miami Beach, FL 33140.

Salutensin® Salutensin-Demi™

(Hydroflumethiazide, Reserpine Antihypertensive Formulation)

Brief Summary of Prescribing Information (12) 10/27/78

For complete information consult Official Package Circular.

WARNING

This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

CONTRAINDICATIONS

Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

WARNINGS

Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or

without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients.

Use in Pregnancy

Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

PRECAUTIONS

Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia

(especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride if necessary, discontinuation of therapy.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

PHYSICIAN completing pathology residency in September 1982 seeks location with pathology group with emphasis on surgical pathology. Graduate of University of Tennessee School of Medicine. Contact Dr. William D. Crump, 1027-B Beacon Parkway East, Birmingham, AL 35209.

FAMILY PRACTICE resident seeks practice location in July 1983. Contact John D. Sites, M.D., 2002 Philip Dr., Muncie, IN 47302.

ANESTHESIOLOGIST seeks to relocate in state in solo, group or institutional practice. Contact M. T. Olivo, Jr., M.D., Box 794, Oxford, MS 38655.

GENERAL PRACTITIONER seeks practice location in small community. Contact Keith Hummell, M.D., 405 Mesaba Ave., Apt. 5C, Duluth, MN 55806.

OPHTHALMOLOGIST seeks practice location upon completion of military service in January 1982. Contact John R. Wood, M.D., 8430 Rocky Path, San Antonio, TX 78250.

BOARD ELIGIBLE PATHOLOGIST seeks practice opportunity. Graduate of University of Mississippi School of Medicine; residencies, UMC. Contact Marianna G. Pardue, M.D., 315 Cedarwood, Jackson, MS, 39212.

BOARD CERTIFIED FAMILY PRACTITIONER seeks practice location. Currently completing military obligation and available 7/82. Contact John E. Bailes, Jr., M.D., 5405 Hackney Circle, Bossier City, LA 71111.

ADVERSE REACTIONS

Hydroflumethiazide

Skin-rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation.

Reserpine

Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares.

USUAL DOSE

1 tablet b.i.d.

SUPPLIED

Bottles of 100 and 1000 scored 50 mg. tablets.

References:

1. Propranolol in the treatment of essential hypertension. Veterans Administration Cooperative Study Group on Antihypertensive Agents. *JAMA* 237:2303-2310, 1977.
2. Five-year findings of the hypertension detection and follow-up program: I. Reduction in mortality of persons with high blood pressure, including mild hypertension. Hypertension Detection and Follow-up Program Cooperative Group. *JAMA* 242:2562-2571, 1979.
3. The 1980 Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med* 140:1280-1285, 1980.

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FAMILY MEDICINE, OBGYN, OR PEDIATRIC PRACTICE OPPORTUNITY. Opening for Board certified or qualified family, ObGyn, or pediatric physician. 3-year-old practice located in metropolitan Miss. community of 50,000 in new facility. Patients pay-as-they-go, NO MEDICAID. GUARANTEED INCOME. Another opening in 2 years. Contact: M.B.C., P.O. Box 16968, Jackson, MS 39236-0968; (601) 366-7422.

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IN CONCLUSION

Few magazines report the hazards of smoking in a thorough and consistent manner, says the American Council on Science and Health. In a survey of 18 major magazines from 1965 to 1981, a period of much newsworthy information about smoking and disease, the ACSH noted that those magazines which do not accept tobacco advertising did an excellent job of reporting and those with more than 5% of their ad revenue from cigarette ads did a poor job. "The 'freedom' to smoke is everyone's, but the decision to adopt the habit should be an informed one," said ACSH.

The Dept. of HHS has sponsored conferences and commissioned a new report on HMOs, in an effort to attract private sector interest as the Administration moves to end federal support. Predicting that HMO enrollment will reach 27 million by 1990 if current trends continue, the report notes that the worsening economic picture favors continued growth of HMOs, as employers seek ways to save money on healthcare. There are now 260 HMOs (10.5 million members), compared to 39 HMOs (3.5 million members) in 1971.

The worldwide eradication of smallpox in 1977 eliminated the last remaining need for smallpox vaccinations for the general public. Yet, according to the Centers for Disease Control, more than 2.8 million doses of the vaccine were distributed in 1980 in the U.S. alone, some of which are being used inappropriately. An article in JAMA (May 21) criticizes use of the vaccine to treat recurrent genital herpes simplex infection, and urges strict limitations on use of the vaccine, such as to protect laboratory workers.

Physicians' fees rose at a rate of 0.6% in April, exceeding the 0.4% increase for all items in the Consumer Price Index, but less than the 0.9% increase for all services in the index. Hospital room charges rose 0.7%; dental services increased 0.9%; and prescription drug charges were up 1.5%. During the last 12-month period, charges for physicians' services increased at a 10.3% rate. The all-items index rose at a rate of 6.6% during the period, and the all-services index rose 11.2%.

Hospital briefs...Some 200 people have participated in an Ohio hospital's program allowing people to pay off hospital bills by working in housekeeping, laundry, maintenance, grounds, and kitchen...Hospital attending staff physicians should be allowed to unionize, ruled the National Labor Relations Board. The case questioned whether staff MDs in hospitals affiliated with medical schools are considered part of management...If trends continue, hospital rates will reach \$4,000 per day by the year 2,000, predicts the Health Insurance Association.

BactrimTM

(trimethoprim and sulfamethoxazole/Roche)

succeeds

Bactrim is useful for the following infections when due to susceptible strains of indicated organisms (see indications section in summary of product information):

Expanding its usefulness in antimicrobial therapy



in recurrent UTI...

a continuing record of high clinical effectiveness against common uropathogens

in acute otitis media in children...

effective against both major otic pathogens... with b.i.d. convenience

in acute exacerbations of chronic bronchitis in adults...

clears the sputum and lowers its volume... on b.i.d. dosage

in shigellosis...

faster relief of diarrhea than with ampicillin²

BACTRIMTM (trimethoprim and sulfamethoxazole Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides, patients with documented megaloblastic anemia due to folate deficiency, pregnancy at term, nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus, infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended, therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: General: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with

careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:*

Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarthritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100, Tel-E-Dose[®] packages of 100; Prescription Packs of 20 and 28. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500, Tel-E-Dose[®] packages of 100, Prescription Packs of 40. Pediatric Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml), cherry flavored—bottles of 100 ml and 16 oz (1 pint). Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).



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BactrimTM succeeds

in recurrent urinary tract infection

from site to source

Bactrim continues to demonstrate high clinical effectiveness in recurrent urinary tract infections. Bactrim reaches effective levels in urine, serum, and renal tissue¹...the trimethoprim component diffuses into vaginal secretions in bactericidal concentrations¹... and in the fecal flora, Bactrim effectively suppresses Enterobacteriaceae^{1,2} with little resulting emergence of resistant organisms.

1. Rubin RH, Swartz MN. *N Engl J Med* 303:426-432, Aug 21, 1980. 2. Data on file, Medical Department, Hoffmann-La Roche Inc.

maximizes results with B.I.D. convenience

BactrimTM DS

160 mg trimethoprim and 800 mg sulfamethoxazole

DOUBLE STRENGTH TABLETS

AUG 5 1982

NEW YORK ACADEMY
OF MEDICINE



* due to susceptible strains of indicated organisms

Please see previous page for summary of product information.

N.Y. ACADEMY OF MEDICINE
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10029

August 1982

JOURNAL
of the **MISSISSIPPI**
State Medical Association



**Carcinoma of Nasopharynx —
Mississippi Experience**

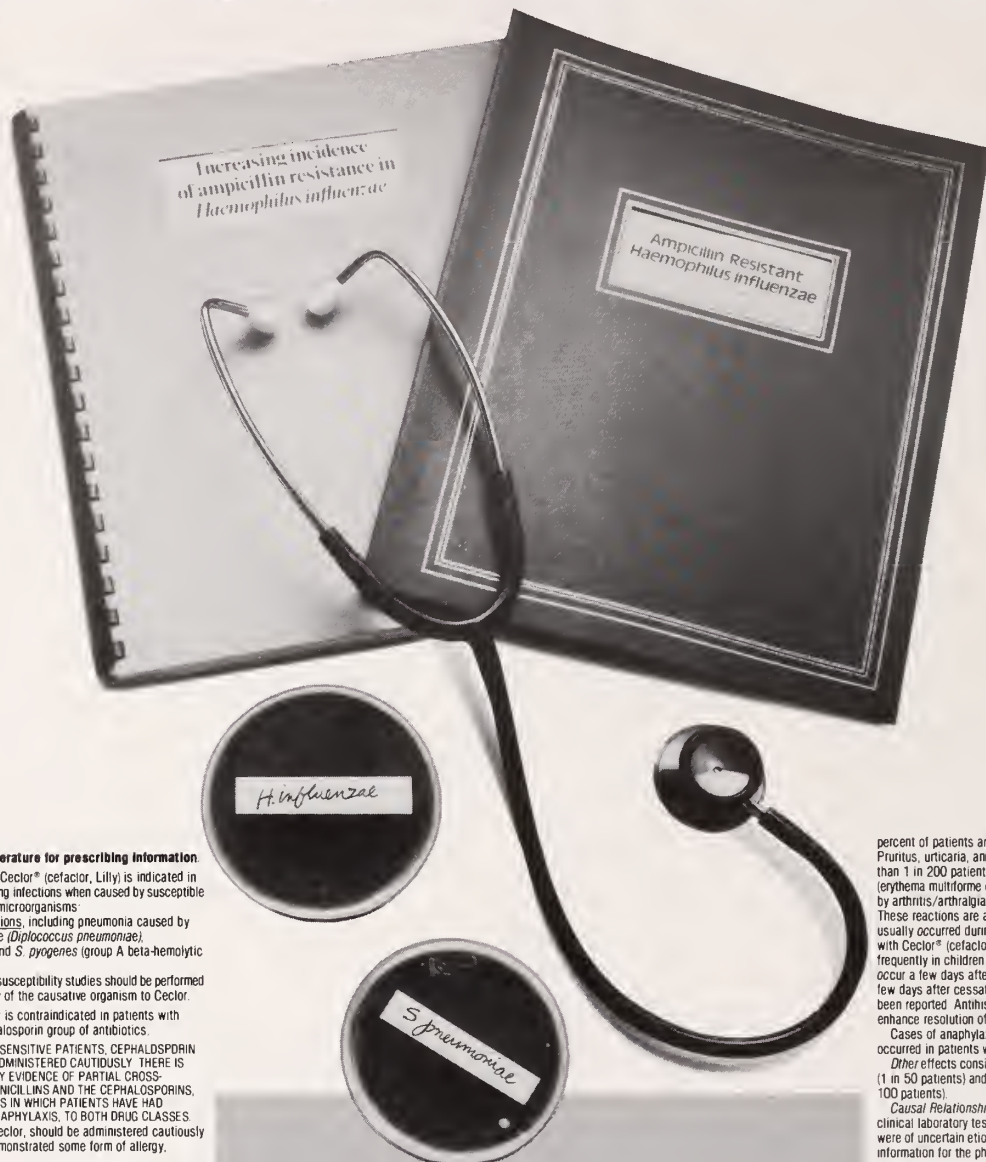
Radiological Seminar CCXXIII

**Maternal Mortality in Mississippi:
1979-1980**

Address of the President

125th Anniversary Year — Mississippi State Medical Association

An added complication... in the treatment of bacterial bronchitis*



Brief Summary.

Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefactor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefactor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefactor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coomb testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in fetuses given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefactor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Ceclor.

Hypersensitivity reactions have been reported in about 1.5

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.^{1,6}

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.⁷

Ceclor®

cefactor

Pulvules®, 250 and 500 mg

percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor® (cefactor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain: Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic: Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic: Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal: Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). (100281R)

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8:91, 1975.
2. Antimicrob. Agents Chemother., 11:470, 1977.
3. Antimicrob. Agents Chemother., 13:584, 1978.
4. Antimicrob. Agents Chemother., 12:490, 1977.
5. Current Chemotherapy, edited by W. Siegenthaler and R. Luthy, II, 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 13:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases, edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett, p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.



200066

ALL FOR ONE ONE FOR ALL



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Alexandre Dumas'
The Three Musketeers
and D'Artagnan

ONE FOR ALL – One tablet treats pinworm
in any patient, regardless of age or body weight.*
Obviates need to calculate individual dosages.

A single tablet eradicates pinworm in 95% of patients.

*Contraindicated in pregnant women and in persons who have shown hypersensitivity to the drug.

VERMOX[®] CHEWABLE TABLETS
(mebendazole)



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Please see complete Prescribing Information on adjacent page.

VERMOX[®] CHEWABLE TABLETS

(mebendazole)

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Tabs #4
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each family
member*



DESCRIPTION VERMOX (mebendazole) is methyl 5-benzoylbenzimidazole-2-carbamate.

ACTIONS VERMOX exerts its anthelmintic effect by blocking glucose uptake by the susceptible helminths, thereby depleting the energy level until it becomes inadequate for survival. In man, approximately 2% of administered mebendazole is excreted in urine as unchanged drug or a primary metabolite. Following administration of 100 mg of mebendazole twice daily for three consecutive days, plasma levels of mebendazole and its primary metabolite, the 2-amine, never exceeded 0.03 µg/ml and 0.09 µg/ml, respectively.

INDICATIONS VERMOX is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (common roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections. Efficacy varies as a function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Whipworm	Common Roundworm	Hookworm	Pinworm
cure rates				
mean	68%	98%	96%	95%
(range)	(61-75%)	(91-100%)	—	(90-100%)
egg reduction				
mean	93%	99.7%	99.9%	—
(range)	(70-99%)	(99.5%-100%)	—	—

CONTRAINDICATIONS VERMOX is contraindicated in pregnant women (see Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

PRECAUTIONS PREGNANCY: VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

ADVERSE REACTIONS Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

DOSAGE AND ADMINISTRATION The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time. For the control of common roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days. If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

HOW SUPPLIED VERMOX is available as chewable tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets. VERMOX (mebendazole) is an original product of Janssen Pharmaceutica, Belgium.

US Patent 3,657,267
December 1979

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125th Anniversary Year

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HYPERTENSION:



METHYLDOPA? RESERPINE? INDERAL? COUNTLESS THOUSANDS WOULD BE BETTER OFF WITH

Today, INDERAL—instead of methyldopa, instead of reserpine.

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INDERAL blocks beta-receptor sites *in the heart* to reduce heart rate and cardiac output—reducing cardiac work load—sparing an overburdened heart.

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*Please see following page
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INDERAL® BRAND OF propranolol hydrochloride A beta-adrenergic blocking agent

BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

CONTRAINDICATIONS

INDERAL is contraindicated in: 1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL, 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

WARNINGS

CARDIAC FAILURE. Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta-blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. INDERAL acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by INDERAL's negative inotropic effect. The effects of INDERAL and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during INDERAL therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, INDERAL therapy should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS DURING ANESTHESIA with agents that require catecholamine release for maintenance of adequate cardiac function, beta blockade will impair the desired inotropic effect. Therefore, INDERAL should be titrated carefully when administered for arrhythmias occurring during anesthesia.

IN PATIENTS UNDERGOING MAJOR SURGERY beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, INDERAL should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since INDERAL is a competitive inhibitor of beta receptor agonists, its effects can be reversed by administration of such agents e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA. Because of its beta-adrenergic blocking activity, INDERAL may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY. The safe use of INDERAL in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit.

Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of INDERAL may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to cataplexy, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Miscellaneous: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

ORAL

DOSAGE AND ADMINISTRATION

HYPERTENSION. Dosage must be individualized. The usual initial dosage is 40 mg INDERAL twice daily, whether used alone or added to a diuretic. Dosage may be increased gradually until adequate blood pressure is achieved. The usual dosage is 160 to 480 mg per day. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

While twice-daily dosing is effective and can maintain a reduction in blood pressure throughout the day, some patients, especially when lower doses are used, may experience a modest rise in blood pressure toward the end of the 12 hour dosing interval. This can be evaluated by measuring blood pressure near the end of the dosing interval to determine whether satisfactory control is being maintained throughout the day. If control is not adequate, a larger dose, or 3 times daily therapy may achieve better control.

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

INTRAVENOUS

The intravenous administration of INDERAL has not been evaluated adequately in the management of hypertensive emergencies.

OVERDOSAGE OR EXAGGERATED RESPONSE

IN THE EVENT OF OVERDOSAGE OR EXAGGERATED RESPONSE THE FOLLOWING MEASURES SHOULD BE EMPLOYED:

BRADYCARDIA: ADMINISTER ATROPINE (0.25 to 1.0 mg) IF THERE IS NO RESPONSE TO VAGAL BLOCKADE. ADMINISTER ISOPROTERENOL CAUTIOUSLY.

CARDIAC FAILURE: DIGITALIZATION AND DIURETICS.

HYPOTENSION—VASOPRESSORS: e.g., LEVATERENOL OR EPINEPHRINE (THERE IS EVIDENCE THAT EPINEPHRINE IS THE DRUG OF CHOICE).

BRONCHOSPASM: ADMINISTER ISOPROTERENOL AND AMINOPHYLLINE.

HOW SUPPLIED

INDERAL (propranolol hydrochloride)

TABLETS
No. 461 Each scored tablet contains 10 mg of propranolol hydrochloride in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 462 Each scored tablet contains 20 mg of propranolol hydrochloride in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 464 Each scored tablet contains 40 mg of propranolol hydrochloride in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 468 Each scored tablet contains 80 mg of propranolol hydrochloride in bottles of 100 and 1,000. Also in unit dose package of 100.

INJECTABLE

No. 3265—Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10.

Reference: 1. Feis, E. D. Hypertension (Suppl. II) 3:230 (Nov-Dec.) 1981.

7997/482

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NEWSLETTER

August 1982

Dear Doctor:

Peer review panels for health insurance claims are subject to attack under the federal antitrust laws, said the U.S. Supreme Court in a 6-3 decision. Although the case involves a chiropractor, it is believed to have implications for medicine and other professions. Dissenting justices Burger, Rehnquist and O'Connor stated that the decision would vastly curtail the peer review process.

"Few professionals or companies will be willing to expose themselves to possible antitrust liability through such activity," said the justices. The lawsuit involved a chiropractor who charged that a chiropractic review panel disputing some of his claims to an insurance company was a vehicle to fix prices.

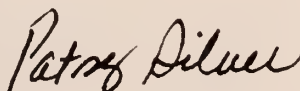
The AMA supported a HCFA proposal to modify requirements for certifying hospitals, skilled nursing facilities, intermediate care facilities, and home health agencies providing services to Medicare and Medicaid beneficiaries. The AMA said the proposal would eliminate red tape and provide more flexible options for state agencies without compromising quality of care.

Physicians' fees rose at a rate of 0.6% in May, trailing the percentage increase in the all-items and all-services components of the CPI (both 1.0%). The overall medical care index increased 0.7%; hospital room charge index increased 0.3%. For the 12 month period, increases were: physicians' fees, 9.6%; overall medical care, 12.0%; and hospital room charges, 16.9%.

Nonprofit HMOs that convert to for-profit status should be required to repay the federal grants that helped them to get started, the AMA said. Protesting proposed regulations allowing the secretary of HHS to waive all or part of the repayment, the AMA termed "inappropriate" the amendment permitting profit-making entities to take advantage of public funds awarded the HMOs.

Nearly half of all physicians believe their practices will be affected by prepaid health plans in the next ten years. That was a finding of a study by Louis Harris and Associates. Of the 1,814 physicians surveyed, 60% expressed unfavorable attitudes toward prepaid health care, citing inferior physician/patient relationships as the main disadvantage.

Sincerely,



Patsy Silver
Managing Editor

NOW THERE IS A BETTER ALTERNATIVE TO STOOL EXAMS. ENTERO-TEST.

ENTERO-TEST® Adult, and Pediatric, a nylon line coiled inside of a gelatin capsule. The Pediatric string is 90cm and the Adult string is 140cm. Both capsules are designed to retrieve duodenal contents without intubation.

ENTERO-TEST® has the following advantages:

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- No Radiation
- Outpatient and Inpatient Use

Studies have confirmed the following applications for the Entero-Test:

PARASITES:

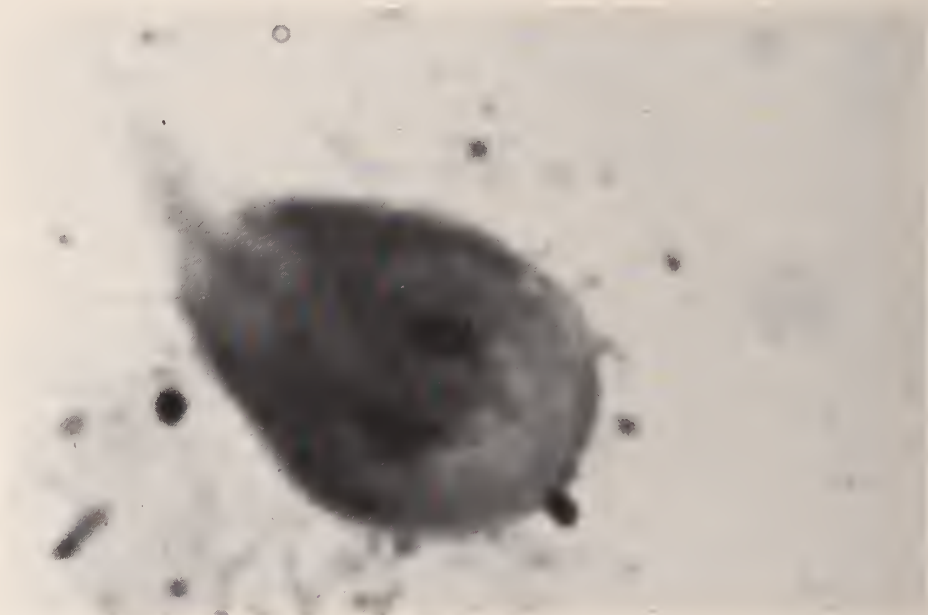
Those parasites that live primarily in the duodenum or bile ducts often are more readily seen in the duodenal contents than in the stool. These include *Giardia lamblia* (motile trophozoites), *Strongyloides stercoralis* (larvae and/or eggs in advanced stages of development), *Clonorchis sinensis* (eggs), *Fasciola hepatica* (eggs), *Trichostrongylus orientalis* (eggs), and *Isospora* (coccidia).

SALMONELLA TYPHI:

Multiple stool exams cultured over several weeks or duodenal intubation are the most commonly used procedures. The Entero-Test is as efficient as intubation but simpler and more comfortable. New studies have further confirmed superior applicability over other procedures.

SMALL INTESTINAL MICROFLORA (Bacterial overgrowth):

Chronic Diarrhea caused by anaerobic and aerobic bacteria in infants and children was easily identified using the Entero-Test. The string test was comparable to or better than duodenal aspirate in all cases.



REFERENCES

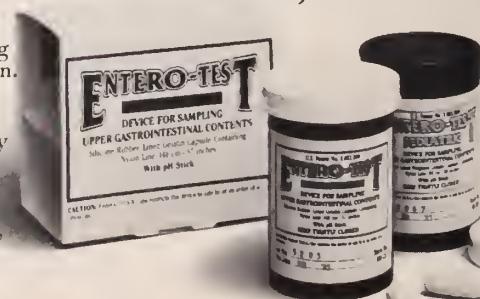
1. Babb, R.R., Beal, C.B., Use of a Duodenal Capsule for Localization of Upper Gastrointestinal Hemorrhage, *GUT* 15:492, 1974.
2. Beal, C.B., et al., A New Technique for Sampling Duodenal Contents, *Am. J. Trop. Med. & Hyg.* 19:349, 1970.
3. Bezjak, B., Evaluation of a New Technique for Sampling Duodenal Contents in Parasitologic Diagnosis, *Am J Dig Dis* 17:845, 1972.
4. Mahmoud, AAF., Warren, KS.: Algorithms in the Diagnosis and Management of Exotic Diseases II. Giardiasis, *J. Infect. Dis.* 131:621, 1975.
5. Thomas, GE., et al: Use of the Entero-Test Duodenal Capsule in the Diagnosis of Giardiasis, *S. Afr. Med. J.* 48:2219, 1974.
6. Kuberski, T.T., et al: Disseminated Strongyloidiasis, *West. J. Med.* 122:504, 1975.
7. Gilman, R.N., Hornick, RB: Duodenal Isolation of *Salmonella typhi* by String Capsule in Acute Typhoid Fever, *J. Clin. Microbiol.* 3:456, 1976.
8. Benavente, L., Gotuzzo, E., Guerra, J., et al: Diagnosis of *Salmonella typhi* by culture of duodenal string capsule, *N. Engl. J. Med.* 304:54, 1981.
9. Colon, AR: Sampling of Duodenal Contents by a Nylon Line, *J. of Peds.*, 89:513, 1976.
10. Gracey, M., Suharjono, Sunoto: Use of a Simple Duodenal Capsule to Study Upper Intestinal Microflora, *Arch. Dis. Child* 52:74, 1977.
11. Baron J.H: The clinical use of gastric function tests, *Scand. J. Gastroent. Suppl.* 6:9, 1970.
12. Rosenthal, P., Liebman, W.M: Comparative Study of Stool Examinations, Duodenal Aspiration, and Pediatric Entero-Test for Giardiasis in Children, *J. Pediatr.* 96:278, 1980.
13. Liebman, W.M., Rosenthal, P: The string test for gastroesophageal reflux, *Am. J. Dis. Child* 134:775, 1980.

Giardia lamblia



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References: 1. Williams RL, Karacan I: Introduction, chap. 1, in *Sleep Disorders: Diagnosis and Treatment*, edited by Williams RL, Karacan I, Frazier SH. New York, John Wiley & Sons, 1978, p. 2. 2. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 3. Kales A et al: *JAMA* 241:1692-1695, Apr 20, 1979. 4. Kales A et al: *J Clin Pharmacol* 17:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. 5. Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 6. Kales A et al: *Clin Pharmacol Ther* 19:576-583, May 1976. 7. Kales A, Scharf MB, Kales JD: *Science* 201:1039-1041, Sep 15, 1978. 8. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 9. Dement WC et al: *Behav Med* 5(10):25-31, Oct 1978. 10. Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 11. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. 12. Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. 13. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 14. Kales A, Kales JD: *Pharmacol Physicians* 4(9):1-6, Sep 1970. 15. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

The Physician's Sleep Glossary

Some common sleep laboratory terms

poly•som•no•graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la•ten•cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af•ter sleep on•set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to•tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.¹

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.²

re•bound in•som•nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.³

Efficacy objectively demonstrated in the sleep laboratory—the most valid environment for measuring hypnotic efficacy.

In numerous sleep laboratory investigations patients fell asleep sooner, slept longer and woke up less during the night^{3,12} with

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Compared with temazepam and other hypnotics, onset of sleep is more rapid⁴ with

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Fewer middle-of-the-night awakenings⁴ with

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More total sleep time on nights 12 to 14 of therapy⁴ and continued efficacy for up to 28 nights⁵ with

Dalmane®

Rebound insomnia is avoided upon discontinuation^{3,4,7} of

Dalmane®

Low incidence of morning "hang-over"¹⁴ with

Dalmane®

The efficacy of Dalmane has been studied in over 200 clinical trials with more than 10,000 patients.^{3,15} During long-term therapy, which is rarely required, periodic blood, kidney and liver function tests should be performed. Contraindicated in patients who are pregnant or hypersensitive to flurazepam.

Please see summary of product information on following page.



ROCHE
PRODUCTS INC.
Manati, Puerto Rico
00701

Dalmane®
flurazepam HCl/Roche
15-mg/30-mg capsules

Dalmane[®] ©
(flurazepam HCl Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, light-headedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



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Manati, Puerto Rico 00701

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Many patients presented with physical symptoms are suffering from psychiatric illness, but are unaware of it. And while not all who suffer from mental illness or emotional problems need hospital treatment, hospitalization may be essential to provide a therapeutic environment in which the patient can effectively deal with his or her problems.

Riverside Hospital is a 56-bed, short-term care facility which provides intensive treatment of patients suffering from psychiatric illnesses, alcoholism, and drug dependencies. In Riverside's open, non-institutional environment, traditional and new, progressive psychotherapies are utilized.

Above all, care at Riverside is aimed at treating the patient with respect and dignity, fostering self-esteem, and returning the patient to independence and a satisfying, productive and happy life.

Riverside is licensed by the Mississippi Commission on Hospital Care, and is fully accredited by the Joint Commission on Accreditation of Hospitals.

The medical staff includes a large number of psychiatrists in private practice in the Jackson area. A toll-free number, 1-800-962-2180, has been established at the hospital for referral service to physicians on the active medical staff.

Physicians who have patients who would benefit from the type of treatment approach offered by Riverside may obtain referral information by contacting the Director of Admissions.

Riverside Hospital

P. O. Box 4297, Jackson, Mississippi 39216
Telephone: (601) 939-9030
Incoming Mississippi WATS: 800-962-2180

DATELINE

Preview Of Banquet Speaker

Jackson, MS - Mark Russell, political satirist and humorist, will be the special guest speaker for MSMA's membership banquet set for May 13, 1983, during the association's 115th Annual Session. MSMA members can get a preview of the noted entertainer by watching the Mark Russell Comedy Special on Wednesday, August 25, at 9:00 p.m. on the ETV network. The program is one of several Mark Russell specials programmed each year.

Physicians Fight Drunk Drivers

Jackson, MS - MSMA members are encouraged to respond to requests for participation in the association's program to remove drunk drivers from Mississippi highways. A volunteer committee has been assembled which will organize and direct activities of Physicians Against Drunk Driving (PADD) and encourage the formation of auxiliary chapters of Mothers Against Drunk Driving (MADD), with the goal of reducing the drunk driver's toll in death, injury, and property damage.

Traffic Fines Will Supplement EMS

Jackson, MS - Beginning last month, fines for moving traffic violations included an extra \$5. The added charge, authorized by the 1982 legislature and effective July 1, will be used for local emergency medical services. Fines will be collected on such violations as speeding, DWI, and reckless driving. Based on the numbers of such violations reported by the Mississippi Highway Patrol, the new law is estimated to generate nearly \$2 million per year for added EMS support.

Robins Award Nominations Open

Jackson, MS - Component societies of MSMA have been notified of the opportunity to submit nominations for the MSMA/Robins Award for Community Service. The award recognizes men and women who are actively engaged in the practice of medicine who render exemplary service to their communities. The award will be presented at the association's 115th Annual Session in Biloxi. Nominations should be made in writing and received at the MSMA office by January 3, 1983.

Office Management Workshops Set

Jackson, MS - Medical assistants are invited to register for office management workshops sponsored by MSMA and the AMA. Sessions are scheduled for September 1 at the Coliseum Ramada Inn, Jackson, and September 2 at the Royal D'Iberville Hotel, Biloxi. Topics for both workshops include: personnel management; patient management and public relations; collections and insurance handling; and health law. The registration fee of \$25.00 includes lunch, breaks, and workshop materials.

Famous Pairs.

*They work so
well together.*

One of man's most amazing explorations and scientific adventures, the successful Gemini flight program was a triumph of imagination and teamwork. Two men learned to operate in space, to rendezvous, to dock, and to work outside their spacecraft in the hard vacuum of outer space. Not only did they coordinate their efforts with ground backup, they also complemented each other's activities within the close confines of the space capsule.



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...another well-known pair that works so well together! Ninety-five percent of colon/rectal surgeons surveyed* added Tucks pads concomitantly to hemorrhoidal treatment programs they recommended.



Anusol-HC[®] Suppositories / Cream with Hydrocortisone Acetate

The #1 physician-prescribed product for hemorrhoids and other common anorectal disorders**

- ☐ **Antiinflammatory**, to relieve edema, burning, itching, pain
- ☐ **Astringent**, to help promote healing
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And, when pain is a special problem, Anusol Ointment offers the benefits of the anesthetic, pramoxine HCl.

TUCKS[®] Pre-Moistened Hemorrhoidal / Vaginal Pads

The #1 hemorrhoidal pad† for added external relief and gentle cleansing of fecal residue

- ☐ Soothes, cools, comforts the irritation and itch of hemorrhoids and other common anorectal disorders
- ☐ Hygienic rectal wipe—an integral part of the anorectal regimen

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**WARNER
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*Meeting of Am Soc Colon / Rectal Surgeons, May 1980.

**Based on total prescriptions filled for hemorrhoidal preparations during the first three quarters of 1981. The National Prescription Audit, IMS America Ltd, Sept 1981.

†1981 data from leading marketing research organization.

ANUSOL-HC[®] Suppositories / ANUSOL-HC[®] Cream

Before prescribing, please see full prescribing information. A Brief Summary follows:

Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in external and internal hemorrhoids, proctitis, papillitis, cryptitis, and fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol[®] Suppositories or Ointment.

CONTRAINDICATIONS

Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

WARNINGS

The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

PRECAUTIONS

General

Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.

Pregnancy

See "WARNINGS"

Pediatric Use

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

DOSAGE AND ADMINISTRATION

Anusol-HC Suppositories—Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

Store between 59°-86°F (15°-30°C)

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MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 19-23, 1983, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610

State and Local

Mississippi State Medical Association, 115th Annual Session, May 11-15, 1983, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, July 6-9, 1983, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39221.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 3rd Wednesday, January, May, and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. J. Barry Gilbert, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Robert L. Coggin, Pres. and Secy., 965 Avent Dr., Grenada 38901. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Pano-la, State, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March,

June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Albert H. Laws, Secy., 816 Second Ave. North, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, June, September, December. Robert D. Holbert, Secy., P.O. Box 1502, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Douglas F. Thomas, Secy., 415 South 28th Ave., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly
Mississippi State Medical Association
735 Riverside Drive
Jackson, MS 39216

North Mississippi Medical Center
830 Gloster Avenue
Tupelo, MS 38801

Forrest General Hospital
Box 1897
Hattiesburg, MS 39401

Mississippi Baptist Hospital
1225 N. State Street
Jackson, MS 39201

Gulf Coast Community/Gulfport
Memorial Hospital Consortium
4642 W. Beach Boulevard
Biloxi, MS 39531

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Delta Medical Center
Greenville, MS 38701

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Biloxi Regional Medical Center
1559 Lafayette St.
Biloxi, MS 39533

Mississippi Radiological Society
316 Medical Arts Building
Jackson, MS 39201

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

Mercy Regional Medical Center
100 McAuley Drive
Vicksburg, MS 39180

North Panola County Hospital
Drawer 160
Sardis, MS 38666

Singing River Hospital
2809 Denny Avenue
Pascagoula, MS 39567

Magnolia Hospital
Alcorn Drive
Corinth, MS 38834

Greenwood Leflore Hospital
1508 Leflore Avenue
Greenwood, MS 38930

South Washington County Hospital
Drawer 398
Hollandale, MS 38748

Counsel to Authors

THE JOURNAL welcomes manuscripts which should be submitted to the Editors at 735 Riverside Drive, Jackson, MS 39216, in original and at least one duplicate copy. They must be typewritten double spaced on 8½ by 11-inch white paper. **Brief manuscripts (about 2,500 words or 8 pages) will be given preference over longer articles.**

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All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

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References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus*, volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes

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Illustrations consist of all material which cannot be set into type such as photographs, line drawings, graphs, charts, and tracings. Illustrations should be submitted separately from text copy. Figures and drawings should be professionally prepared with black ink on white paper. Photographs should be of high resolution, unmounted, untrimmed, glossy prints. Each must be clearly identified. No charges are made to authors for up to four illustration engravings. More are not permitted unless voted on by two editors and extra costs must be absorbed by the author.

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In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material.

A thesis summary of 75 to 100 words must accompany each manuscript.

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In addition, in view of *The Copyright Revision Act of 1976*, effective Jan. 1, 1978, transmittal letters to the editor should contain the following language: "In consideration of the Mississippi State Medical Association's taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the MSMA in the event that such work is published by the MSMA." We regret that transmittal letters not containing the foregoing language signed by *all* authors of the submission will necessitate delay in review of the manuscript. — *The Editors.*

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and worthlessness

fatigue

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headache

vague aches

and pains

sadness

psychic and

somatic anxiety

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looking out from the human eye
as conceived in a schematic model.

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Limbitrol brings a special—and specific—quality of relief to most anxious depressed patients. Insomnia, for example, responds with particular promptness. Other symptoms likely to respond within the first week of treatment include anorexia, agitation and psychic and somatic anxiety. And, as the depression and anxiety are alleviated, in many cases so are such related somatic symptoms as headache, palpitations, and various vague aches and pains.

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may be the best approach**

Many patients respond readily to a single bedtime dose of Limbitrol, a convenient schedule that may enhance compliance and helps relieve the insomnia associated with anxious depression. Limbitrol also offers a choice of other regimens: t.i.d., or a divided dose with the larger portion h.s. In all cases, caution patients about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as driving or operating machinery.

in moderate depression and anxiety

Limbitrol® IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline
(as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline
(as the hydrochloride salt)

Specific therapy with h.s. dosage convenience

Please see summary of complete product information on following page.

LIMBITROL® TABLETS Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving)

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies.

Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation at either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated. Sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50

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ORIGINAL PAPERS

Carcinoma of Nasopharynx — Mississippi Experience

ANUPAM ROUTH, M.D.,
BERNARD T. HICKMAN, M.D., and
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CARCINOMA OF THE NASOPHARYNX is not a very common tumor in the United States of America. There were about 1,300 new patients in 1978.¹ This constitutes about 0.2% of all cancer and 4% of all head and neck cancer. The incidence rate is 0.6 per 100,000 people.

The high incidence of this cancer among the Chinese living in Asia suggested some genetic trait, but no such genetic defect has been discovered. But when the Chinese migrated to the United States, the locally born younger generations had a much lower incidence than the Chinese born older generations.^{2, 3} Singapore has an exceptionally high incidence of nasopharynx cancer, with significant risk differences between the major racial groups and Chinese dialect groups in the population. The age-standardized incidence rates per 100,000 per year are 18.7 and 7.1, respectively for male and female Chinese; 4.8 and 0.6 among Malays; and 0.9 and 0.0 for Indians.⁴

In this paper we report the result of treatment of patients in our department between 1970-76. Electing 1976 as the cutoff point enables us to have at least four years follow-up. We shall review the clinical features, histology, stage of the disease, and survival rate.

From the Division of Radiotherapy, University of Mississippi Medical Center, Jackson, MS.

The authors report the results of treatment of carcinoma of the nasopharynx at the University of Mississippi Medical Center. Most patients were in the advanced stage. Eighty percent of the patients presented with neck nodes. Twenty-two patients were treated for cure between 1970-76; nineteen of them were in Stage IV. The four year survival rate for all stages is 36.3%. One patient died of unknown cause and is not included in the list of survivors. If that patient is included, the four year survival rate improved to 41%. Six out of nineteen Stage IV patients survived, and all these patients are free of disease. The follow-up period of these patients is between 48-116 months. All but one patient was seen in follow-up in 1980. One was lost to follow-up after 50 months. All the patients were treated with a dose ranging between 6000-6900 rads.

Anatomy

Nasopharynx is a cuboidal space measuring 4cm in transverse diameter, 4cm in height, and 2-3cm in antero-posterior diameter. The anterior limit is the choana, through which it is continuous with the nasal cavities. Its roof is attached to the base of the

skull and slopes downward to become continuous with the posterior pharyngeal wall, forming overall the vault of the nasopharynx. The lateral wall is composed of the torus tubarius, the eustachian tube orifice, and that portion of the mucosa of the fossa of Rosenmueller extending up to its apex and junction with the roof. The inferior limit of the nasopharynx is level with the plane of the hard palate.

The first echelon of lymphatic drainage of the nasopharynx is in the parapharyngeal lymph nodes. Because these are difficult to examine, the actual incidence of involvement of this group of nodes is not known. The next group of lymph nodes commonly involved are upper deep cervical nodes (66%), jugulo-digastric nodes (70%), spinal accessory nodes (28%), jugulo-omohyoid nodes (34%), and inferior cervical nodes (20%).⁵

All patients are staged according to TNM Classification recommended by American Joint Committee for Cancer Staging and End Results.

Selection of Patients

There were 30 patients treated for cure by the University of Mississippi Medical Center from 1970-76. Of these 30 patients, six were excluded from the report, three had non-Hodgkin's lymphoma, one was recurrent, one had plasmacytoma, and one received only 2400 rads.

Of the 24 patients, one patient with T₃N₃M₀ disease developed severe pain on the first day of treatment. X-ray of the lumbar spine revealed metastasis at L-1. He lived for six months only.

Another patient had such extensive disease that it was thought treatment could only be palliative, even though a high dose of 6500 rads was administered. The patient lived for 42 months although he developed recurrence after 20 months. The rest of the 22 patients were treated for cure.

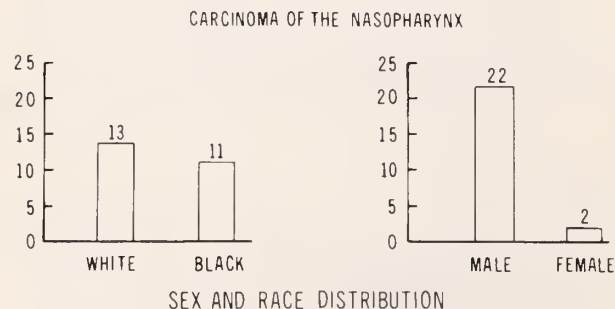


Figure 1.

Age and Sex Distribution

There were 22 males and 2 females. The ratio of black and white is almost equal. The blacks in Mississippi are 40% of the population. (Details are shown in Figures 1 and 2).

Pathology

Our pathologist (W. J.) reviewed all the pathology materials available and reclassified them. We could get pathology material on only 17 patients. In 7 patients we were unsuccessful. All of the patients fell into the group of lymphoepithelioma or poorly differentiated squamous cell carcinoma. Lymphoepithelioma was subdivided again into Schmincke and Regaards. In Schmincke it is composed of large ill-defined carcinoma cells with large vascular nuclei and nucleoli with some tendency to form anastomosing trabecula and numerous lymphocytes situated within and between the trabeculae. Regaards differs from Schmincke in the tendency of the tumor to form a syncytium. It is less common than the Schmincke type. The separation of lymphoepithelioma into Regard and Schmincke type is only helpful in aiding histopathological diagnosis and has nothing to do with the prognosis of the patient. Recent review of the records of the patients seen at M.D. Anderson Hospital showed no prognostic difference based on histology type. (Personal communication of Dr. Giffler to Dr. Johnson).

Of the 17 patients reviewed, they were distributed as follows: 10 were of Schmincke type, 3 were of Regaards type, and 4 were squamous cell. Of the 7 patients who could not be reviewed, 5 were squamous cell carcinoma and 2 were of lymphoepithelioma. Here we took the original diagnosis as was in our charts.

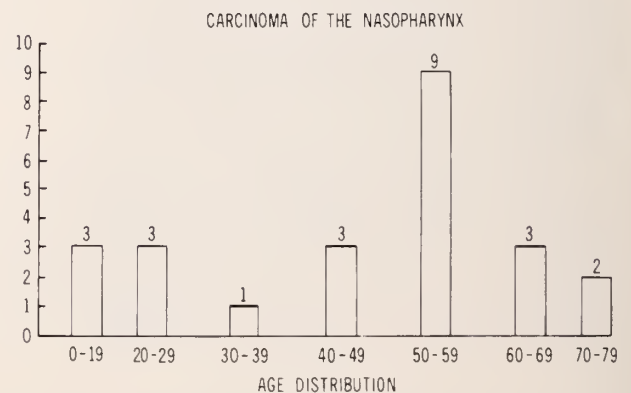


Figure 2.

After the initial review, we asked our pathologists to look at the pathological material of the 8 patients who were alive. Seven patients' slides could be reviewed. No histological or cytological features were found to explain their survival compared to the patients who did not survive.

Symptoms

The symptoms in our patients are tabulated in Table 1. We also compared the symptoms of our patients with symptoms of a large series of 350 Chinese patients in Taiwan as reported by Chiang and Griem.⁶

In our series, 9 patients presented with neck nodes as their only symptom, of which 7 were unilateral and 2 were bilateral. One patient presented with fullness in the ear, one with nasal obstruction, and one with nasal bleeding as their only symptoms.

The high incidence of patients presenting to the doctor with a neck node mass without any other symptom is surprising.

Staging

One patient presented with enlarged neck nodes as the only symptom. The histology was metastatic lymphoepithelioma. No primary was ever found. The patient died after 18 months from the disease. The patient developed metastasis in the pelvis. This patient was staged as Stage $T_0N_1M_0$.

The distribution of the patients is illustrated in Table 2. When these patients are staged, grouped distributions of the patients are as follows:

Stage I	$(T_1N_0M_0)$	1
Stage II	$(T_2N_0M_0)$	2
Stage III	$(T_3N_0M_0)$	2
Stage IV	T_1 or T_2 or $T_3N_1M_0$	19
	T_4N_0 or N_1M_0	
	Any T N_2 or N_3M_0	
	Any T any N M_1	

Radiotherapeutic Management

Twenty-two patients were treated for cure. The radiation dose varied from 6000-6900 rads to the nasopharynx. The most common dose to the primary site was 6500 rads. The neck nodes received 5000 rads. The field was moved away from the spinal cord after 4500 rads had been delivered. A common field arrangement is shown in Figure 3.

The nominal standard dose (NSD) varied from

TABLE 1
SYMPTOMS OF MISSISSIPPI PATIENTS COMPARED TO
CHINESE PATIENTS

Symptoms	No. of Patients	Mississippi Pt.	Taiwan Pt.
Nasal Bleeding	6/24	25%	44.2%
Nasal Obstruction	3/24	12.5%	30.3%
Headache	5/24	20.8%	40.2%
Hearing Loss	4/24	16.6%	22.2%
Diplopia, Visual disturbance	3/24	12.5%	20%
Numbness of Face	1/24	4.16%	12%
Sore Throat	1/24	4.16%	8.6%
Hoarseness of Voice			5.3%
Swallowing disturbance			5.3%
Hemoptysis	2/24	8.32%	
Earache, fullness in ear	5/24	20.8%	
Trismus	2/24	8.32%	
Lump in neck as only symptom	9/24	37.5%	

TABLE 2
DISTRIBUTION OF PATIENTS ACCORDING TO
NODAL STATUS

	N_0	N_1	N_{2a}	N_{2b}	N_3
T_0		1			
T_1	1		3	2	
T_2	2		1		
T_3		1	2	2	2
T_4	3	1		1	2

1552 (6000 rads in 34 fractions in 69 days) to 1848 (6500 rads in 33 fractions in 45 days). The most common NSD was between 1785-1825. The variation of NSD is mainly due to the number of days it took to complete because of the development of mucositis in patients as a result of radiotherapy treatment. Various patients needed different periods of rest from treatment.

Result

Eight patients out of 22 patients (36.36%) treated were alive for more than four years. All but one were seen sometime in 1980. One patient after 50 months left Mississippi and moved to the North. The patient had an appointment to come to the University of Mississippi Medical Center after one year, in late 1979, but he did not return. The stage, dose, and survival time of these eight patients are in Table 3.

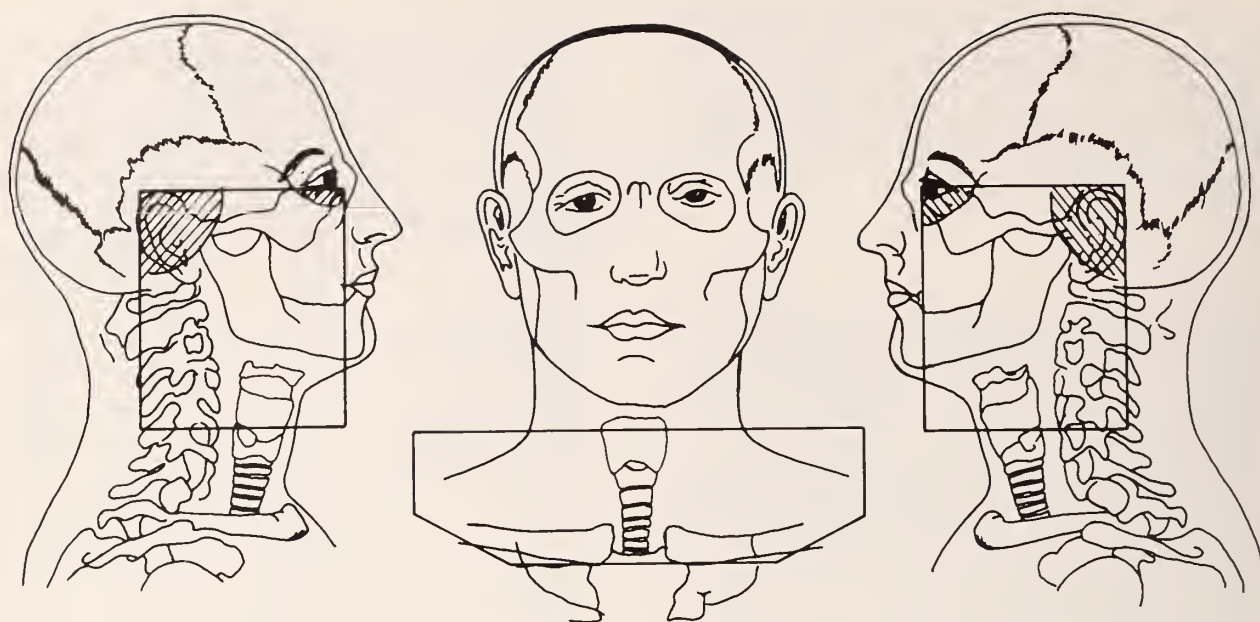


Figure 3. Common treatment portals. Two parallel opposed field and a lower single anterior field.

TABLE 3
HISTOLOGY, STAGE, DOSE, SURVIVAL TYPE OF PATIENTS WHO SURVIVED A MINIMUM OF 48 MONTHS

Name	Histology	Stage	TNM	Date of RX	Dose	NSD	Last Seen Alive	Mos. Alive After RX
J.A.	L.E.-S	IV	T ₃ N ₃ M ₀	9- 9-75	6000r	1714	5- 7-78	56
G.C.	Sq. cell	IV	T ₃ N ₂ M ₀	9-26-75	6900r	1817	12-16-80	62
E.D.	L.E.-S	IV	T ₁ N ₂ M ₀	5- 3-74	6500r	1789	7-26-78	Moved North
H.E.	L.E.-S	II	T ₂ N ₀ M ₀	8-13-75	6500r	1785	5-21-80	57
L.G.	L.E.-S	I	T ₁ N ₀ M ₀	5-21-75	6500r	1824	6-20-80	60
A.P.	L.E.-S	IV	T ₄ N ₁ M ₀	12-12-73	6500r	1822	2- 6-80	74
F.P.	L.E.-R	IV	T ₁ N ₃ M ₀	11-14-70	6000r	1693	8- 1-80	116
R.T.	Sq. cell	IV	T ₄ N ₃ M ₀	2-24-76	6500r	1665	2-80	48

* L.E. = Lymphoepithelioma S = Schmincke type R = Regaards type

Discussion

The survival from nasopharynx carcinoma is poor. Generally the patients are presented in advanced stages.

Nasopharynx is also one of the "silent" areas like pyriform sinus, where tumors could be far advanced before diagnosis.

Many patients (80%) present with enlarged neck nodes, making them Stage III or IV. In our series, we had only *one* Stage I and *two* Stage II patients. Most of our patients were in Stage IV. One Stage I patient is alive after 60 months. Out of two Stage II patients, one is alive after 57 months. Out of 19 Stage IV, six survived. All of our surviving patients

are without any disease. We did not include one patient who died after 36 months of unknown cause.

C. C. Wang reported five year relapse-free survival figure of 17% in advanced areas. From Israel, Har-Kedar⁷ reported 8.2% five year survival. This low survival is probably due to treatment by orthovoltage radiation and very conservative treatment used before 1968. Since 1968 new, aggressive technique has been used with much better survival figures. Bedwinek⁸ reported relapse-free five year survival of 20%. Atell⁹ reviewed the cancer patient survival in 1976. In his review of 871 cases of carcinoma of the nasopharynx, the five year survival of all stages was 26%. Shanmugaratnam reported a five year survival rate of patients in Singapore to be 25.3%. At three years there was no difference in survival rates between different histologic types, but at five years squamous cell carcinomas had poorer prognosis than other types.

In our series, the relapse-free survival at four years is 36% in all stages and 30% in Stage IV cases. Even in advanced nasopharyngeal carcinoma, aggressive treatment may help the patient. ★★★

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References

1. National Cancer Institute, the third national cancer survey: Advanced three-year report, 1969-1971 Incidence, DHEW Publication N. (NIH) 74-637, 1974.
2. Quisenberry, W. B. and Reimann-Jasinski, I.: Ethnic difference in nasopharyngeal cancer in Hawaii. In Muir, C. S. and Shanmugaratnam, K. (eds.): *Cancer of the Nasopharynx*. UICC Monograph Series: 1967, Vol. 1, pp. 77-81.
3. Zippin, C., Tekawa, T. S., Bragg, K. U. et al.: Studies in heredity and environment in cancer of the nasopharynx. *J. Nat. Cancer Inst.* 29:283-490, 1962.
4. Shanmugaratnam, K., Chan, S. H., De-The, G., Goh, J. E. H., Khor, T. H., Simons, M. J. and Tye, C. Y.: Histopathology of nasopharyngeal carcinoma. *Cancer* 44:1029-1044, 1979.
5. Wang, C. C.: Curative radiation therapy for carcinoma of the nasopharynx. *Bull. N. Y. Acad. Med.* 50: 9, pp. 1001-1007, 1974.
6. Chiang, Tze-Chun and Griem, Melvin L.: Nasopharyngeal cancer. *Surg. Clin. N. Amer.* 53(1):121-133, 1973.
7. Har-Kedar, I., Chaichik, S. and Hercberg, A.: Nasopharyngeal carcinoma at the Tel-Hashomer Government Hospital, Israel. A 20 year survey (1951-1970). *Clin. Radiol.* 25:403-407, 1974.
8. Bedwinek, John M., Perez, Carlos A. and Keys, David J.: Analysis of failures after definitive irradiation for epidermoid carcinoma of the nasopharynx. *Cancer* 45:2725-2729, 1980.
9. Axtell, L. M., Asire, A. J. and Myers, M. H.: Cancer patient survival, report number 5, National Cancer Institute, DHEW Publication No. (NIH) 77-992, 1976.

Radiological Seminar CCXXIII: A Gamut for "Hot" Kidneys on ^{99m}Tc -Labeled Bone Images

DOROTHY S. LIN, M.D.

Jackson, Mississippi

"HOT" KIDNEYS (the intensity of ^{99m}Tc -MDP uptake in renal parenchyma is equal to or greater than skeletal uptake in the thoracolumbar spine) on scintiscans have been occasionally noticed.

Case Example

A 40-year-old black male was admitted for evaluation of pulmonary infiltrates and severe back pain of four weeks duration which extended from the shoulder region to lower rib cage. During the past two months, he had experienced night sweats, fever, chills, cough, anorexia, and weight loss. Recently, his fever had spiked to 103-104°F. He also had hemoptysis and prostate tenderness.

The diagnosis of blastomycosis was established by demonstrating the organism on KOH sputum preparations. In nine days, he received 240 mg of amphotericin B intravenously and responded well. At the end of this course of treatment, his creatinine clearance dropped from 100 ml/min (normal, 117 ± 20 ml/min) to 50 ml/min and his serum creatinine level increased from 0.8 mg% (normal, 0.7-1.7 mg%) to 2 mg%. His BUN value remained normal.

On the ninth day of his antifungal treatment, a bone scintiscan with ^{99m}Tc -MDP was performed because of severe bone pain and negative radiographs. The study showed increased uptake in the T7 vertebra, the coracoid process of the right scapula, and the tip of the left 11th rib, which were all symptomatic and were thought to represent blastomycosis bony infections. The uptake in the renal parenchyma of both kidneys was markedly increased (see Figure 1) and was attributed to renal toxicity caused by amphotericin B treatment.



Figure 1. Posterior view (40-year-old male with blastomycosis). The bone image performed on the ninth day after he received 240 mg of amphotericin B showed increased uptake in the renal parenchyma and in one of the left lower ribs.

Gamut

The manifestation of "hot" kidneys on bone imaging most likely represents some kind of renal injury or renal parenchymal deposition of bone im-

Sponsored by the Mississippi Radiological Society.
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ing radionuclide avid minerals such as calcium or iron. According to the literature and our own experience, the various causes are: (1) renal damage due to chemotherapy,¹ antibiotics,² and irradiation,³ (2) renal ischemia such as acute tubular necrosis,⁴ renal artery stenosis,⁵ cirrhosis of liver (reduced renal plasma flow),⁶ and antecedent septic shock while receiving gentamicin,⁷ (3) a part of the general manifestations of hypercalcemia,⁸ iron overload,⁶ sickle cell disease,² lymphoma, leukemia, multiple myeloma,⁹ diabetes mellitus,⁶ and membranous lupus nephritis, (4) alteration in tissue distribution such as receiving injection of radiographic contrast material between injection of the radiopharmaceutical and performance of the bone scan,¹⁰ and poor bone uptake due to loss of bone mass secondary to extensive marrow hyperplasia in thalassemia major.⁶

Therefore, clinical correlation and knowledge of possible causes can be essential for interpreting this interesting finding. A gamut of the known causes organized according to their prevalence is shown as follows:

COMMON

1. Hypercalcemia⁸
2. Iron overload⁶
3. Post nephrotoxic antibiotics²
4. Post chemotherapy, especially intraarterial administration^{1, 6}
5. Radiation nephritis³
6. Sickle cell disease²
7. Liver cirrhosis⁶

UNCOMMON

1. Renal artery stenosis⁵
2. Acute tubular necrosis⁴
3. Lymphoma
4. Leukemia
5. Diabetes mellitus⁶
6. Poor bone uptake⁶

RARE

1. Multiple myeloma⁹
2. Antecedent septic shock⁷
3. Lupus nephritis
4. Following injection of radiographic contrast material¹⁰ ★★★

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References

1. Lutrin, C. L., McDougall, R. and Goris, M. L.: Intense concentration of Technetium-99m pyrophosphate in the kidneys of children treated with chemotherapeutic drugs for malignant disease. *Radiology* 128:165-167, 1978.
2. Sty, J. R., Babbitt, D. P. and Sheth, K.: Abnormal Tc-99m-methylene diphosphonate accumulation in the kidneys of children with sickle cell disease. *Clin. Nucl. Med.* 5:445-447, 1980.
3. Wistow, B. W., McAfee, J. G., Sagerman, R. H., Thomas, F. D. and Grossman, Z. D.: Renal uptake of Tc-99m-methylene diphosphonate after radiation therapy. *J. Nucl. Med.* 20:32-34, 1979.
4. Lavelle, K. J., Park, H.-M., Moseman, A. M. and Lewis, S.: Renal hyperconcentration of ^{99m}Tc-HEDP in experimental acute tubular necrosis. *Radiology* 131:491-495, 1979.
5. Lantieri, R. L., Lin, M. S., Martin, W. and Goodwin, D. A.: Increased renal accumulation of Tc-99m-MDP in renal artery stenosis. *Clin. Nucl. Med.* 5:305-309, 1980.
6. Koizumi, K., Tonami, N. and Hisada, K.: Diffusely increased Tc-99m-MDP uptake in both kidneys. *Clin. Nucl. Med.* 6:362-365, 1981.
7. Glass, E. C., DeNardo, G. L. and Hines, H. H.: Immediate renal imaging and renography with ^{99m}Tc methylene diphosphonate to assess renal blood flow, excretory function, and anatomy. *Radiology* 135:187-190, 1980.
8. Arbona, G. L., Antonmattei, S., Tetalman, M. R. and Scheu, J. D.: Tc-99m-disphosphonate distribution in a patient with hypercalcemia and metastatic calcifications. *Clin. Nucl. Med.* 5:422, 1980.
9. Adams, K. J., Shuler, S. E., Witherspoon, L. R. and Neely, H. R.: A retrospective analysis of renal abnormalities detected on bone scans. *Clin. Nucl. Med.* 5:1-7, 1980.
10. Crawford, J. A. and Gumerman, L. W.: Alteration of body distribution of ^{99m}Tc-pyrophosphate by radiographic contrast material. *Clin. Nucl. Med.* 3:305-307, 1978.

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Maternal Mortality in Mississippi: 1979-1980

WILLIAM B. WIENER, M.D.

Jackson, Mississippi

IN 1957, THE MISSISSIPPI State Medical Association (MSMA) established a committee to study, as a continuing research and educational program, the maternal mortality cases occurring each year in the state of Mississippi. The study has emphasized education directed at improved maternal care and has received the support of the medical profession in our state. The Committee on Maternal and Child Care recently completed its study data for the calendar years 1979-80.

Death certificates from the Mississippi State Board of Health furnished to the committee indicate that there were 5 and 2 maternal deaths in Mississippi in 1979 and 1980, respectively. The number of live births to Mississippi residents (in state and out of state) totalled 45,919 in 1979 and 47,819 in 1980 (provisional).

The maternal mortality rate for Mississippi residents (maternal deaths per 100,000 live births) was 10.9 in 1979 and 4.2 in 1980. The maternal mortality rates for the United States in 1979 and 1980 were 7.8 and 6.9 respectively.

We are glad again to report a low maternal mortality rate for Mississippi residents. If we indeed have only two maternal deaths in 1980, we have established a new and gratifying record. It is paramount to continue to instruct and offer good prenatal care to every pregnant patient. By so doing, we can smoothly integrate our ambulatory care into hospital care for delivery and/or treatment of the high risk patient. Also, by working together with other physicians in specialties such as family practice, internal medicine, anesthesia, and pediatrics and by utilizing the services of the nutritionists and social service workers, we may be able to continue to keep our maternal mortality rate at a very low level.

The Committee on Maternal and Child Care Reports study data for 1979-1980 and notes a continuing decline in maternal mortality rates in Mississippi.

Techniques of obtaining and reviewing information on maternal deaths have not changed appreciably during the 22 years of study. The questionnaire type of inquiry has been exclusively employed. No "on the spot" investigations of hospital records or interviews of physicians or hospital personnel have been conducted except under rare circumstances involving hospitals in Jackson. The data sheet used was developed by the committee before the study began and has undergone only minor changes since then. One of the data sheets, together with a letter from the chairman of the committee, is sent to the physician who last attended the patient. He or she is asked to complete and return the data sheet and add any pertinent information in a supplementary note. If the physician does not reply, two followup letters are sent at appropriate intervals. In some cases, personal attempts have been made by members of the committee, the State Board of Health, officers of the association, or local obstetricians to obtain information. Letters requesting additional information occasionally have been sent to the responding physician by the committee, if it seemed likely that he could supply further information which might be of value.

Following receipt of the data sheet and other information, all identifying marks are removed so that anonymity is preserved. A copy of the data sheet is then sent to a member of the committee for review prior to the next meeting. At the meeting of the committee, the case is summarized by the member who has studied and evaluated it according to the criteria set out in the AMA "Guide for Maternal Death Studies." The evaluations are discussed by

Chairman, Committee on Maternal and Child Care.
Committee members — William B. Wiener, M.D., Jackson; W. E. Godfrey, M.D., Natchez; John C. Morrison, M.D., Jackson; Edwin M. Meek, Jr., Greenwood; K. Ramsay O'Neal, M.D., Hattiesburg; Wendell H. Stockton, M.D., Amory; W. W. Walley, M.D., Waynesboro.

the committee, agreed to or voted on if there is a division of opinion, and then furnished to the attending physician.

The committee studied 7 maternal deaths occurring in 1979 and 1980. All replies to the committee's inquiries are evaluated as to their usability (see Table I) and usable replies are classified according to the adequacy of the data furnished (see Table II). In order to receive the highest rating, which is 5, the questionnaire for the committee's study must be completely filled out, a relevant explanatory note attached, and an autopsy report included if available. Cases rated 1 or 2 are often difficult to evaluate because of gaps in data received.

TABLE I
STUDY MATERIAL

	1979		1980	
	No.	Percent	No.	Percent
Total cases	7*		2	
Replies received	5*	71	1	50
Replies usable	5	71	1	50

* The two cases where no reply was obtainable were signed by lay coroners. In one case the patient was dead on arrival at the hospital; in the other, the patient had not sought medical care because of religious reasons.

TABLE II
ADEQUACY OF DATA

Category	1979		1980	
	No.	Percent	No.	Percent
5	3	60.0	1	50.0
4	1	20.0		
3	1	20.0		
2				
1			1	50.0

TABLE III
CAUSES OF DEATH

	1979		1980	
	No.	Percent	No.	Percent
Direct	5	100	1	50.0
Indirect	0		0	
Undetermined	0		1	50.0

Following the AMA "Guide for Maternal Death Studies," the committee classifies maternal deaths as either direct obstetric deaths or indirect obstetric deaths. Direct obstetric deaths are defined by the guide as those in which the cause of death is due to a condition directly related to the pregnancy such as hemorrhage, toxemia, infection, anesthesia or vascular disease. Indirect obstetric deaths are those resulting from disease which was present before or developing during pregnancy but was obviously aggravated by the physiological effects of the pregnancy and caused the death. Classification of maternal deaths studied by the committee in 1979 and 1980 as to direct or indirect deaths is shown in Table III.

TABLE IV
CAUSES OF DIRECT OBSTETRIC DEATH

	1979		1980	
	No.	Percent of All Deaths Studied	No.	Percent of All Deaths Studied
Hemorrhage	0			
Toxemia	0			
Infection	2	40.0		
Vascular accident	1	20.0	1	50.0
Anesthesia	2	40.0		

TABLE V
AVOIDABILITY

	1979		1980	
	No.	Percent	No.	Percent
Avoidable	5	100.0	0	0
Non-avoidable	0	0	1	50.0
Undetermined	0	0	1	50.0

TABLE VI
AVOIDABLE FACTORS

	1979		1980	
	No.	Percent	No.	Percent
Professional	3	75.0	0	0
Hospital	0	0	0	0
Patient	0	0	0	0
Undetermined	1	25.0	0	0

MATERNAL MORTALITY/Wiener

The direct obstetric deaths studied by the committee have also been classified as to cause in Table IV.

Again, following the AMA "Guide for Maternal Death Studies," the committee determines the avoidability of those maternal deaths studied (see Table V). Avoidability is judged in the ideal academic sense. This concept involves three assumptions: first, the physician possessed all the knowledge currently available relating to the factors

involved in the death; second, by experience, he had reached a high level of technical ability; third, he had available to him all the facilities present in a well organized, properly equipped hospital. Because of the austerity of these criteria, it is then desirable to determine avoidable factors involved in the death rather than label the death preventable, and this is done in Table VI.

The committee wishes to again acknowledge and commend the medical profession's support for this project in our state. Such support has been the cornerstone for the project's success. ★★★



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Address of the President

R. FASER TRIPLETT, M.D.

Jackson, Mississippi

THIS WEEK MARKS THE END of my term as president of the association. It has been a year which Jackie and I have thoroughly enjoyed. We have traveled the state, spoken to most of the component societies, seen a lot of old friends and made many new friends.

During the year, I have stressed the importance of our profession's being involved. I will try not to be too repetitive on that subject; first, because most of you have already heard the sermon, and second, because you in this room are probably among the most involved members we have.

I want to talk to you today about what I consider to be the greatest challenge facing the medical profession. That challenge, in my opinion, is for our profession to address the problem of escalating health care costs.

Let me begin by paraphrasing the remarks made at our MSMA Leadership Conference a few weeks ago by Congressman Sonny Montgomery. He indicated to those in attendance that there is growing concern in Congress about health care costs. There is also frustration among our friends in Washington because of a perceived failure of a "voluntary effort" to address this problem. There is the promise that if something is not done by private enterprise, then Congress must act to bring health care costs under control through government regulation.

In 1981, the overall inflation rate was 8.9 percent. The overall medical services rate of increase was over 12 percent, and the rate of increase for hospital services was almost 19 percent. If present trends continue, physicians' services will cost Americans over \$129 billion by 1990 and hospital services will cost some \$335 billion. Those figures compare with \$35 billion and \$76 billion respectively in 1978.

Health care costs simply cannot be permitted to rise at their present rate. The country cannot afford it, and we as physicians must do something about the problem.

I would suggest that in order to bring costs under control, we must first educate ourselves as well as the public about what is going on regarding health

care in our communities. We should look at the type of medicine we are practicing in our offices and local hospitals. Are you sure in your own mind that you are providing quality medical care at reasonable cost?

" . . . the greatest challenge . . . is for our profession to address the problem of escalating health care costs."

Do you know the cost of hospital and other medical services you are ordering for your patients? Physician services account for some 19 cents of the health care dollar, but based on our orders, we are responsible for some 50 percent of the rest of the health care dollar.

Let me suggest that if you don't know, you should find out the cost of medical services you are ordering. Then when appropriate, order less costly alternatives.

Another area where increased public and professional communication is needed is the area of professional liability insurance.

Both the incidence and severity of malpractice awards are increasing. Increasing awards result in increased professional liability insurance premiums. These increased premiums result in increased practice expenses which are passed on to our patients.

We must appeal to the public, and particularly to our lawmakers for their understanding of this problem. We must seek their assistance in finding solutions to the problem.

One recommendation I would make in this regard is that our legislature enact a collateral source rule. Presently in this state, if a physician is sued for malpractice and the plaintiff alleges damages in time lost from work and medical expenses, the defendant physician's attorney is not allowed to introduce into evidence the payments the plaintiff received for these damages.

Thus, a plaintiff can have his entire medical bill paid by his insurance company, be compensated fully for his time lost from work by unemployment

President, Mississippi State Medical Association, 1981-82.
Read before the House of Delegates, 114th Annual Session,
Biloxi, May 3, 1982.

PRESIDENT'S ADDRESS/Continued

compensation, and then recover the total of those amounts in a malpractice award.

Collateral source legislation has passed in several other states, and I would recommend that we seek passage of such a law during the 1983 legislative session. If we begin now, by joining our Mississippi Medical Political Action Committee and by initiating personal contact with our legislators, we can be successful in this endeavor.

Another area where the public and the profession must seek new alternatives is the area of third party reimbursement. In my opinion, first dollar coverage of medical services should be discouraged. Where first dollar coverage exists, there is an incentive for the insured to seek as much medical care as he can get because "my insurance will pay for it."

We must encourage business leaders to restructure their employees' health benefit package to include higher deductibles and co-insurance.

Many people who have group insurance programs provided as a job benefit have no idea how much the employer is paying for their health care and how much the premium impacts on the final cost of the goods or services they produce.

For example, the single largest supplier to General Motors last year was Metropolitan Insurance at a cost of \$866 million. The second largest supplier was Blue Cross-Blue Shield at a cost of \$435 million. Keep in mind that these two outranked any single producer of steel or any single tire company, and you can visualize what the cost of health care did to the sticker price of automobiles last year. Add to that what the steel supplier and the tire producer paid in health benefits, and you can easily see that the cost of health care played a significant role in the cost of the finished product. I think that you could look at any product or service sold in this country and somewhere back down the line, the cost of health care has had an impact on the price of that product or service.

Again, with respect to third party reimbursement, I believe we need to encourage better coverage of ambulatory care as opposed to institutional care. While many tests and surgical procedures should be done in a hospital, there are also many that can be done on an outpatient basis. The profession should take the lead in encouraging our patients to receive these latter tests on an ambulatory basis where circumstances and facilities permit. Also, we should encourage third-party payors to cover these tests and procedures on an outpatient basis and perhaps to add some incentives for their use.

In Jackson, following a recommendation of the American Medical Association, we have begun to formally meet with our local business leaders to discuss health matters of mutual interest and concern. I believe that such a dialogue can be beneficial in addressing some of the matters I have brought to your attention today.

I urge you to make your component medical society the focal point for this activity in your community. Your MSMA Board of Trustees, officers, and staff are ready to assist you in this endeavor.

I am convinced that our profession can have a positive effect on reducing the cost of medical care while at the same time, maintaining the high standard of quality that our patients deserve and expect . . . and that we want to continue to provide.

I would like to take a moment now to make a few suggestions about the activities of our Mississippi State Medical Association. First, we held a Leadership Conference in March in accordance with a directive from this House of Delegates. We had a program which was both interesting and informative, but only 70 people registered. I think that every physician who attended derived benefits, but we should have had a larger number of participants, particularly from this House of Delegates.

I am recommending that the meeting be held again next year with a similar format. The change I would suggest is in name only. Perhaps our low registration was due to the fact that we called the meeting a "Leadership Conference." Some of our members who are not presently serving in an office or on a council or a committee of the association may have felt the meeting was not designed for them.

My second suggestion involves the nominating process we use to arrive at candidates for offices in the association. I would like to see us have truly competitive races for positions of leadership in MSMA. Along these lines, I would recommend that the bylaws be changed to provide that the nominating committee, which you will select by caucus this morning, continue as a committee to make nominations to the House next year for vacancies in office that will occur at that time.

The nominating committee, which you select each year, would meet at least 60 days before the annual session and select at least two, but no more than three, viable candidates for each vacancy in office. The names of these candidates would be published to the membership prior to the annual session. This process would hold true for all offices in MSMA. The bylaws would be left unchanged as to the number of persons nominated and elected by the House to be submitted to the Governor for his

appointments to the Board of Medical Licensure.

It is my opinion that by giving the nominating committee a greater time span within which to operate, many of our members desirous of holding office in the association will be given a chance to actively seek nomination, thus providing a more broad based group of elected officers.

The third suggestion I would make is that a committee be appointed by the incoming president with the advice of the Board of Trustees to look at the present council and committee structure, component society structure, and trustee districts of MSMA. We have some councils and committees that are not active, and possibly some new ones are needed.

Also, in my opinion changes in physician distribution require a look at trustee districts. I think this committee should study our MSMA structure during the upcoming year and report its findings and recommendations, if any, to the House of Delegates at the next annual session.

I hope you will look closely at these suggestions in the reference committee meeting today and give your input to the committee for their consideration.

In closing, let me say again how much I have enjoyed serving as your president. The many kindnesses you have extended to Jackie and me will be treasured throughout the years. Thank you. ★★

Help Preserve the Heritage Of Medicine in Mississippi

Send your tax-deductible contribution of \$25.00 to help finance construction of a "Country Doctor's Office" at the state's new Agricultural and Forestry Museum in Jackson.

The facility will entertain and educate thousands of visitors to the Capital City each year. Your association's Board of Trustees has endorsed the museum project as an appropriate way to celebrate the MSMA's 125th anniversary year and to tell the story of medicine in Mississippi.

Donors of \$25.00 will receive a limited edition, commemorative plate for office or home.

Donors of \$100.00 or more will receive a plate and will have their names engraved on a plaque at the museum's medical exhibit.



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The President Speaking

PADD Needs Your Support

SIDNEY O. GRAVES, JR., M.D.
Natchez, Mississippi

The statistics are alarming. One-half of all highway deaths are attributable to alcohol. Untold millions of dollars of damage to property and health care costs to the injured survivors are also by-products of intoxicated drivers. The profession, as a first-hand witness to the death and destruction caused by drunken drivers, must move to the front in the fight to remove this menace from our society.

We have taken the first step. At the 1982 Annual Session, the House of Delegates passed a resolution urging the removal of drunken drivers from the highways of our state. A committee of the association has now been appointed. The committee is made up of volunteers who feel strongly about this problem. I was present at their initial meeting and was very impressed.

Dr. Dewey H. Lane of Pascagoula is the chairman of the committee. Dr. Lane has been a prime mover in the effort to "get the drunk from behind the wheel." Other members of the committee are equally interested and impressive. With that interest, I am very enthusiastic about what can and will be accomplished by our profession.

We will be organizing Physicians Against Drunk Driving (PADD). We will be encouraging local auxiliaries to form chapters of MADD (Mothers Against Drunk Driving). We will be analyzing the effectiveness of our Implied Consent Law and comparing it with laws of other states as to their effectiveness. We will be monitoring the enforcement efforts of our law enforcement officers and the conviction rate of our justice court judges and city judges.

I am certain that our profession can have a significant role in reducing the tragic loss of life and injury that occurs on our highways because of drunken drivers. In the coming months, the committee may be calling on many of you for local assistance. Be prepared to donate your time to participate in what can become one of the most positive projects of our profession — the elimination of the intoxicated driver from the roads and highways of Mississippi.

★★★

EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XXIII, Number 8

AUGUST 1982

A Farewell

It is with regret that we say goodbye to Dr. George Martin as he retires from the JOURNAL MSMA as associate editor.

Dr. Martin served many years in this capacity and had an excellent attendance record in journal staff meetings, ably tended his share of responsibilities and duties, and made many scientific contributions in his editorials.

George is a man of many interests, and we wish him well as he retires from active practice within the year.

Mississippi medicine will miss the services and association of this able surgeon.

W. MONCURE DABNEY, M.D.
Editor

A Vision

It had been a long annual session and most of us were anxious to get home and gather up loose ends after our yearly interlude on the coast.

We have become inured to the reading of long rubber-stamped reports, hoping desperately that none will arouse the ire of some sleepy delegate who didn't attend the reference committee.

The break during which we vote in elections (which seldom produce a surprise, much less excitement) at least wakes us for a while. The awards are announced, and no recipients are even there to receive them. Even the installation ceremony only temporarily dispels the pervading ennui.

Then a totally unexpected, unscheduled event occurred, that in one breath made it all worthwhile again!

Our vice speaker, Jimmy Waites, asked for the microphone and delivered this inspiring, impromptu short message:

Proverbs 29:18 — "Without a vision the people perish."

We cannot give what we do not have, nor reproduce what is not ours. Business as usual creates a lack of enthusiasm and spontaneity. The challenge to involvement is missing. The aching needs of our time demand involvement; and the future of our profession requires it.

If we could set aside our pessimism, our fears and reservations, what would be our boldest dream for organized medicine in America?

Mine is for a dynamic renaissance in which we, you and I, the leaders, dare to go back to the basics — to the personal involvement with our patients as persons, not numbers, not lab tests.

The need of our time is for personal, authentic involvement to be encouraged, and taught, and lived, and shared with our fellow physicians. We have the leadership, we have the vision; do we have the desire and dedication? I do, and I invite each of you to go home and become an evangelist with me.

Let's face it. He preached us a sermon, even with a text, that we damned well need to hear and to heed.

ARTHUR A. DERRICK, JR., M.D.
Associate Editor

Each year thousands of visitors to the Capital City will have an opportunity to learn the story of medicine in Mississippi as they tour the "Country Doctor's Office" at the state's new Agricultural and Forestry Museum.

Members of MSMA have an opportunity to help tell that story by sending tax-deductible contributions to finance construction of the exhibit.

Donors of \$25.00 will receive a limited edition, commemorative plate which recognizes the association's 125th anniversary year. Donors of \$100.00 or more will also have their names engraved on a plaque at the exhibit. Contact MSMA headquarters today for more information.

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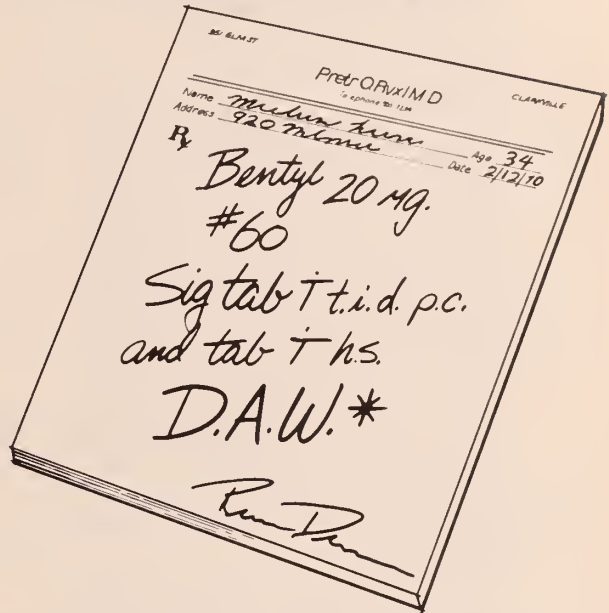


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Reference:

1. Chowdhury AR and Lorber SH: Personal communication, 1980.

(See Product Information on the next page before prescribing Bentyl.)

Although the dose of Bentyl used to show pharmacologic effect was 50 mg, which is a higher single dose than that permitted in the labeling, the dose was considered justified, since the recommended daily dose of injectable Bentyl is 20 mg (2 ml) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg I.M. and, at that time, as a result of the sustained plasma levels from the 20 mg injections at 0 and 4 hours, might show an even higher plasma level than occurs after a single 50 mg dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

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Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the following indications as "probably" effective.

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hypertension, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling, severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of light-headedness and occasionally local irritation.

DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg capsule and syrup. **Adults:** 1 or 2 capsules or teaspoonfuls syrup three or four times daily. **Children:** 1 capsule or teaspoonful syrup three or four times daily. **Infants:** ½ teaspoonful syrup three or four times daily. (Dilute with equal volume of water.)

Bentyl 20 mg: **Adults:** 1 tablet three or four times daily.

Bentyl Injection: **Adults:** 2 ml. (20 mg.) every four to six hours intramuscularly only.

NOT FOR INTRAVENOUS USE

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of July, 1980

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC. Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY Decatur, Illinois 62525 for

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RECOLLECTIONS

"The Traffic of Tragedy," the president's address published twenty years ago in JOURNAL MSMA (August 1962), focused on the flourishing industry in quack remedies. Speaking before the 94th Annual Session, MSMA president Dr. Lawrence W. Long deplored the dangers to the public of fraudulent health care practices and pointed to the financial cost to society — more than a billion dollars a year. He described MSMA efforts to "Be unremitting in our effort to inform the public, guide the sick, and assist in preserving the integrity of medical science to the benefit of all."

News reports in that issue announced the election of Dr. J. P. Culpepper, Jr., of Hattiesburg as vice president of the AMA and the naming of the University of Mississippi's historic medical school building as the B. S. Guyton Building in honor of Dr. Guyton.

Scientific articles included "Coarctation of the Aorta," by Drs. Watts R. Webb and James D. Hardy of Jackson and "Fads and Fancies in the Treatment of Arthritis," by Dr. Russell L. Cecil of New York.

Review A Book

The following books have been received. Medical readers (members of MSMA) interested in reviewing any of these volumes should address their requests to Editor, JOURNAL MSMA, P.O. Box 5229, Jackson, MS 39216. After submitting to the JOURNAL a review for publication, you may keep the books for your personal libraries.

Something Hidden: A Biography of Wilder Penfield. By Jefferson Lewis, Garden City, New York; Doubleday & Company, 1981. \$17.95.

Physician's Handbook: Twentieth Edition. Los Altos: Lange Medical Publications, 1982. \$12.00.

Manual of Clinical Problems in Obstetrics and Gynecology. Edited by Michel E. Rivlin, M.D., John C. Morrison, M.D., and G. William Bates, M.D. Boston; Little, Brown & Company, 1982. \$15.95.

Current Medical Diagnosis & Treatment. Edited by Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. Los Altos: Lange Medical Publications, 1982. \$26.00.

MEDICAL ORGANIZATION

JOURNAL MSMA Welcomes Dr. Derrick, Associate Editor

The JOURNAL MSMA welcomes Dr. Arthur A. Derrick of Durant as associate editor. Dr. Derrick has a long history of service to state medicine and has received the association's highest honor — that of president (1973-74). He also served for six years on the MSMA Board of Trustees, including one year as chairman.

He is a member of the American Medical Association and of North Central Medical Society, which he has served as secretary and president. Since 1950 he has been chief of staff, District II Community Hospital in Durant.

Dr. Derrick received his M.D. degree from the University of Tennessee College of Medicine. He interned at DePaul Hospital in St. Louis and completed a residency in obstetrics and gynecology at Lutheran Hospital in St. Louis. He has practiced medicine in Durant since 1946.

"Dr. Derrick has made previous contributions to MSMA and to our journal," notes Dr. W. Moncure Dabney, editor, "and he comes well qualified for this task."

Dr. Derrick joins Dr. Dabney and associate editor Dr. Myron Lockey as member of the Committee on Publications, which oversees publication of JOURNAL MSMA. Chairman of the Committee is Dr. Lawrence W. Long of Jackson.



SBH Identifies Funding Priorities

Immunizations programs and programs on sexually transmitted diseases were identified as priority areas when the Mississippi State Board of Health met last month to determine how to spend 1983 federal block grant funds.

Decreases in federal funds have forced the Board to reduce funding for some programs and eliminate several others. But SBH officials say that the flexibility individual states have in administering block grants has made it possible to continue many ser-

vices by consolidating programs and using reduced staff.

One victim of last month's funding meeting was the Emergency Medical Services Division, which, instead of receiving a requested increase, found its share of the Preventive Health and Health Services block grant cut by \$146,000.

Board members also voted to eliminate six demonstration programs on developing healthier lifestyles. Funding for the six programs, located at various places in the state, was in excess of \$248,000.

Medical Examiner System Now Under Study

The future of Mississippi's embryonic medical examiner system may be as questionable as some of the deaths the system was intended to resolve.

Difficulties in implementing the system are not new to the three-member governing commission or to Dr. Faye Spruill, who has occupied the post of state medical examiner since July 1979.

The system has faced numerous problems since enabling legislation was passed, but early this year questions about the proposed system and its funding apparently led to the system's current state of limbo. Last month Dr. Spruill began the 1983 fiscal year without operating funds and without an office. The 1982 Legislature eliminated the office's \$112,443 budget for the fiscal year which began July 1 and instead appropriated \$10,000 for a feasibility study to be conducted by the University Medical Center.

Dr. Spruill had designed a plan which would establish three medical examiner districts in the state. Each of the district offices would have a well-equipped laboratory and would be staffed by a forensic pathologist and lab personnel. Costs to set up the three units would total some \$700,000 initially. Under the proposed system the district offices would receive continued funding by contracting with counties in the area for death investigations.

Whether or not the districts could become self-supporting within two or three years as envisioned is one of the questions the UMC study is expected to address. The study is expected to be completed by November, and results will be reported to the 1983 Legislature.

(Continued on page 244)

Family Physicians Meet in Biloxi

Dr. Louis Rubenstein of Ocean Springs was installed as the 34th president of the Mississippi Academy of Family Physicians at the academy's recent annual scientific assembly in Biloxi.

Dr. Ernie Chaney, president of the American Academy of Family Physicians, conducted the installation of Dr. Rubenstein and other MAFP officers, including: Dr. Hardy Woodbridge of Jackson, president-elect; Dr. James Waites of Laurel, vice president; Dr. Eugene Wood of Jackson, secretary-treasurer; and Dr. Joseph Johnston of Mt. Olive, delegate.

Five physicians were installed as MAFP directors, including: Dr. George Bush of Laurel; Dr. James Stingily of Hazelhurst; Dr. Walter Johnston of Vicksburg; Dr. Leonard Brandon of Starkville; and Dr. Malcolm Moore of Tupelo.

Dr. Addison T. Tatum of Petal received the John B. Howell Memorial Award. The award is given for outstanding leadership and services to family medicine in Mississippi. The MAFP Memorial Award was presented to Chester C. Lott, a third year medical student at the University of Mississippi School of Medicine.

The scientific program featured a seminar on nephrology presented by Drs. John Bower, John Kiley, Jack Rubin, Kent Kirchner, and Sybil Raju, all of Jackson. Other scientific programs included discussions of antibiotic-related enterocolitis; prophylactic use of antibiotics; nutrition cultism — facts and fiction about vitamins; hypertension and preventive aspects of coronary artery disease; depression in family practice; and diabetes and the clinical use of newer insulins.



Dr. Hardy Woodbridge of Jackson, right, was named president-elect of the Mississippi Academy of Family Physicians at the MAFP annual meeting in Biloxi. With him, from left, are: Dr. Joseph Johnston of Mt. Olive, delegate; Dr. Eugene Wood of Jackson, secretary-treasurer; and Dr. James Waites of Laurel, vice president.



Dr. Ernie Chaney, president of the American Academy of Family Physicians, left, conducted the installation of Dr. Louis Rubenstein of Ocean Springs as president of the Mississippi Academy of Family Physicians.

UMC Promotes Six Faculty Members

Six School of Medicine and centerwide faculty members moved up to the rank of professor in promotions announced at the University of Mississippi Medical Center.

Dr. Norman C. Nelson, UMC vice chancellor, announced the changes in faculty status for 21 medical school and centerwide faculty members following approval by the Board of Trustees, State Institutions of Higher Learning.

School of Medicine faculty promoted to the rank of professor were Dr. G. William Bates, obstetrics and gynecology; Dr. Jeanette Pullen, pediatrics; and Dr. Seshadri Raju, surgery. Centerwide faculty moving up to the rank of professor were Dr. Lawrence Slobin, biochemistry; and Dr. John E. Hall and Dr. Thomas E. Lohmeier, physiology and biophysics.

Dr. Bates chaired the University of Tennessee Clinical Education Center department of obstetrics and gynecology in Knoxville prior to joining the UMC faculty in 1978. He earned the M.D. at the University of North Carolina School of Medicine.

Dr. Pullen, an M.D. graduate of Tulane University School of Medicine, was a postdoctoral fellow in hematology and an instructor in pediatrics at the University of Tennessee before joining the UMC faculty in 1969. She serves as director of the pediatric division of hematology and oncology.

Dr. Raju earned the medical degree at Christian Medical College in India. Before joining the UMC faculty in 1972 he was a research fellow and a

resident in thoracic surgery at UMC.

Dr. Slobin, on the faculty since 1977, holds the Ph.D. from the University of California at Berkeley. He held postdoctoral fellowships at Weizmann Institute of Science and the University of California at San Diego. Dr. Hall earned the Ph.D. at Michigan State University. He was a National Institutes of Health postdoctoral fellow prior to joining the UMC faculty in 1975. Dr. Lohmeier, who earned the Ph.D. at the University of California at Davis, held postdoctoral fellowships at the University of Missouri Medical School and at UMC. He joined the faculty in 1976.

School of Medicine faculty promoted to the rank of associate professor were Dr. Deirdre Melessa Phillips and Dr. H. Tom Milhorn, Jr., family medicine; Dr. Andrew D. Parent, neurosurgery; Dr. Robert L. Britt, pediatrics; and Dr. Terence M. Keane, psychiatry and human behavior.

Centerwide faculty moving up to the rank of associate professor were Dr. James C. Lynch, anatomy; Dr. Russell Christie, microbiology; and Dr. Beth Hoskins, pharmacology and toxicology.

School of Medicine faculty promoted to the rank of assistant professor were Dr. John P. Foster, family medicine; Dr. Paul F. Malloy and Dr. Patricia Marie Dubbert, psychiatry and human behavior; and Dr. Tawfig Iftekhar Khansur, medicine. Centerwide faculty moving up to the rank of assistant professor were Dr. Nancy Hayes, anatomy; Dr. Craig J. Lobb, Microbiology; and Dr. Charulochana Subramony, pathology.

William Jaquith Awards Presented to UMC Residents



Dr. Nunilon Upano Thomas (third left) and Dr. Martha Jean Murray (second left) received the William Jaquith Award presented by the Department of Psychiatry and Human Behavior at the University of Mississippi Medical Center. Sandoz Pharmaceuticals sponsors the award named in honor of the former director of the State Hospital at Whitfield. It goes to the UMC psychiatry resident who shows the greatest promise during postgraduate training. Dr. Thomas and Dr. Murray tied for this year's award. With them are Dr. Edgar Draper, UMC professor of psychiatry and human behavior and department chairman, Dr. Garfield Tourney, department professor and vice chairman, and Jim McLoughlin, Sandoz medical sciences liaison.

JOURNAL MSMA encourages your participation. Comments, inquiries and suggestions are invited.

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HATTIESBURG AMERICAN photo by Robert Miller



Doctors' Daughters in the News

An enthusiastic crowd of Hattiesburg citizens were on hand to welcome Susan Hammett as she returned home after being named America's Junior Miss in the nationally televised pageant in June. Susan is the daughter of Dr. and Mrs. Larry Hammett of Hattiesburg. Above, welcoming Susan as she stepped off the Amtrak train from New Orleans is her father.

At left is Karen Hopson, who has represented the state for the past year as Miss Mississippi. A swimsuit winner in the Miss America pageant, Karen was also named to the top ten in the Miss America competition. She is the daughter of Dr. and Mrs. Briggs Hopson of Vicksburg.

PERSONALS

JAMES ACHORD of UMC taught a workshop on colorectal cancer in New York in June.

J. RUSSELL BARNES has associated with The Street Clinic in Vicksburg for the practice of family medicine.

WILLIAM BATES of UMC presented a seminar recently at Touro Infirmary in New Orleans.

TERRELL DAVIS BLANTON and C. RON CANNON of Jackson announce the association of R. ALAN DAVIS for the practice of otolaryngology, facial plastic surgery, and head and neck surgery.

JOHN D. BURK announces the opening of his Corinth office for the practice of dermatology at Medical Plaza Building, Alcorn Drive.

EDGAR M. DAPREMONT, JR. announces the opening of his clinic for the practice of ophthalmology at 419 Courthouse Road, Gulfport.

CARL EVERS of UMC presented a report to the Group for Research in Pathology Education in Minneapolis, Minnesota, in June.

ROBERT B. HARRISON of Jackson has been elected to fellowship in the American College of Radiology.

FRED HECKLER of UMC presented a lecture at the University of Oklahoma in Oklahoma City, in June.

JAMES L. HUGHES of UMC recently participated in a Royal College of Surgeons course in London.

RICHARD HUTCHINSON of UMC presented a seminar sponsored by the International Medical Education Corporation in Orlando, Florida.

HERBERT LANGFORD of UMC presented a paper at a meeting of the Endocrine Society in San Francisco.

ANDREW D. PARENT of UMC lectured to the Research Society of Neurological Surgeons in Seattle.

LAMAR WEEMS of UMC spoke during the recent meeting in Biloxi of the Mississippi Hospital Association.

CHARLES H. WILLIAMS announces the opening of his office for the practice of family medicine in association with FRANK A. WOOD, at 2747 Old Canton Road, Jackson.

NEW MEMBERS

BIBIGHAUS, ALEXANDER JOSEPH, III, Tupelo. Born Northampton, PA, June 16, 1942; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned and orthopedic surgery residency, University Medical Center, Jackson, MS, 1969-74; elected by Northeast Mississippi Medical Society.

BROUSSARD, CURTIS ANDREW, Liberty. Born Lafayette, LA, Aug. 23, 1954; M.D., Louisiana State University School of Medicine, Shreveport, 1979; interned, same, one year; elected by Amite-Wilkinson Counties Medical Society.

FINGAR, JAMES RAYMOND, Tremont. Born Port Jefferson, NY, July 4, 1952; M.D., Northwestern University Medical School, Chicago, 1977; interned Huntsville Hospital, Huntsville, AL, one year; elected by Northeast Mississippi Medical Society.

MOORE, DANNY DAVIS, Amory, born Tupelo, MS, July 9, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned and medicine residency, University Medical Center, Jackson 1979-82; elected by Northeast Mississippi Medical Society.

ROUSE, DOUGLAS WESLEY, Hattiesburg. Born Hattiesburg, MS, Aug. 26, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned University Medical Center, Jackson, one year; orthopedic surgery residency, Georgia Baptist and Scottish Rite Hospital, Atlanta, 1977-81; elected by South Mississippi Medical Society.

SAWYER, DAVID NORMAN, Pass Christian. Born Schenectady, NY, Nov. 27, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned Brackenridge Hospital, Austin, TX, one year; elected by Coast Counties Medical Society.

DOCTORS HELPING DOCTORS

Voluntary, tax deductible contributions to MSMA's Disabled Doctors Program may be made to the Caduceus Club of Mississippi. P.O. Box 5229, Jackson, MS 39216.

Medical Examiner System

(Continued from page 239)

The concept of a medical examiner system in Mississippi to replace the lay coroner system has long been supported by a number of organizations, including the Mississippi State Medical Association, the Mississippi State Bar Association, the Mississippi Coroner's Association, the Mississippi Pathologists Association, and numerous law enforcement organizations.

About 1,800 of 4,200 deaths in Mississippi in 1977 were classified as undetermined. According to Dr. Spruill, under a good medical examiner system only about 1 percent to 4 percent of investigated deaths should be ruled undetermined.

Faculty Appointments at UMC

Dr. Milton Kramer was named professor of psychiatry and human behavior in 17 School of Medicine and centerwide faculty appointments announced at the University of Mississippi Medical Center in Jackson.

Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean, announced the appointments following approval by the Board of Trustees, State Institutions of Higher Learning.

Dr. George W. Shannon was named an associate professor of family medicine. New assistant professors are Dr. Max R. Taylor, medicine; Dr. Alexander John Haick, Jr., surgery; Dr. James U. Morano, radiology; Dr. Scott Searcy Campbell, psychiatry and human behavior; and Dr. Donald Blaine Sittman, Jr., biochemistry.

Joining the faculty as instructors were Dr. Cecil Cleveland Graham and Dr. Bharti V. Patel, anesthesiology; Dr. Marcia K. Newsom, family medicine; Dr. George East Patton, Jr., Dr. Mack Clifton Furr, Dr. Rafel Dwaine Rieves and Dr. Paul Joseph Harris, medicine; Dr. Mikio Kataoka, medicine (research); Dr. Phyllis Joan Frostenson, radiology; and Dr. David J. Dzielak, physiology and biophysics.

Dr. Kramer, on the University of Cincinnati faculty since 1960, earned the B.S. at the University of Illinois and the M.D. at the Illinois College of Medicine. He interned and took residency training at Cincinnati General Hospital. An adjunct professor of psychology at the University of Cincinnati since 1979, Dr. Kramer had served as professor of psychiatry there since 1972.

Dr. Shannon earned the B.S. at St. Francis College and the M.D. at Case Western Reserve University. He interned and took residency training at University Hospital of Cleveland. An associate pro-

fessor of family medicine at the University of Tennessee since 1978, Dr. Shannon had chaired UT's Jackson-Madison County General Hospital family medicine department since 1978 and had directed the family medicine residency program there since 1976.

Dr. Taylor earned the B.S. at Belhaven and the M.D. at UMC. He interned and took residency training at the Medical Center. Dr. Haick, an Ole Miss graduate, earned the M.D. at UMC. He interned and took residency training at Vanderbilt and was a resident at UMC.

Dr. Morano attended the University of Mississippi and earned the M.D. at UMC, where he had been a resident since 1978. Dr. Campbell earned the B.A. at Florida State, the M.S. at Montana State and the Ph.D. at the University of Florida, and had been a postdoctoral fellow at Harvard Medical School since 1981. Dr. Sittmann earned the A.B. and Ph.D. degrees at the University of North Carolina and had held a postdoctoral fellowship at Florida State University since 1979.

Dr. Graham earned the B.A. at Northeast Louisiana University and the M.D. at the LSU School of Medicine. He interned at Memorial Hospital in Savannah and took residencies at Charity Hospital in New Orleans and at the University Hospital in Charlottesville. He had been in private practice in Virginia since 1972. Dr. Patel, an M.D. graduate of Government Medicine College, took residencies at Civil Hospital, Albany Medical Center Hospital and Mount Vernon Hospital.

Dr. Newsom earned the B.S. at Millsaps and the M.D. at UMC, where she took residency training. Dr. Patton is a University of Mississippi graduate. He holds the M.D. from UMC and took residency training there.

Dr. Furr earned the B.S. at Millsaps College. He earned the M.D. and held a residency at UMC. Dr. Rieves earned the B.S. at Ole Miss and the M.D. at UMC. He took residency training at Vanderbilt University. Dr. Harris earned the B.S., M.S. and M.D. degrees at Emory University. His residency training was at UMC. Dr. Kataoka, an M.D. graduate of Okayama University Medical School, took residencies at Kure Kyosai and Shuso Hospitals. He had been a trainee in hematology, oncology and cancer immunology at Okayama since 1977. Dr. Frostenson earned the B.A. at Eastern New Mexico University and the M.D. at the New Mexico School of Medicine. Her residency training was at Vanderbilt University. Dr. Dzielak earned the B.S. at Cornell University and the Ph.D. at UMC. He had been a postdoctoral fellow at UMC since 1981.

POSTGRADUATE CALENDAR

Aug. 13-15, 1982

ADVANCED CARDIAC LIFE SUPPORT
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Anesthesiology, the School of Nursing, the Medical Center Division of Continuing Health Professional Education and the American Heart Association, Mississippi Affiliate.

Coordinator: George Lyon, M.D., instructor in anesthesiology, University of Mississippi School of Medicine.

This program is designed to train and certify health professionals in ACLS. Registrants must be medical, nursing, paramedical or allied health personnel whose daily occupation demands proficiency in ACLS. Other participants may audit the program at the course director's discretion. Course fee: \$175. Credit: 16 contact hours, Category I of the AMA Physician's Recognition Award.

Aug. 21-22, 1982

ADVANCED TRAUMA LIFE SUPPORT
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Surgery and the Medical Center Division of Continuing Health Professional Education.

Coordinator: Briggs Hopson, M.D., Region IV Committee on Trauma, American College of Surgeons.

This course is designed for the physician who does not deal with major trauma on a day-to-day basis and who must evaluate and manage seriously injured patients immediately after an injury. It will provide information on rapid assessment, resuscitation, stabilization and transfer.

FUTURE CALENDAR

Aug. 26; Sept. 9; Sept. 23, 1982

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Education. For more information, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone (601) 987-4914.

MEDICO-LEGAL BRIEF

No Defamation of Patient From Withdrawal Letter

A patient had no cause of action for defamation against a clinic and its manager for sending her a letter stating that the clinic and its physician wished to withdraw from treatment of her and her family, the North Dakota Supreme Court ruled.

In August 1979, the patient settled a malpractice suit against a hospital and a physician who was a stockholder and employee of the clinic. The manager of the clinic sent her a letter dated December 6, 1979, in which he informed her that the clinic and all physicians associated with it wished to withdraw from treatment of her and her family. The letter said that the reason for the withdrawal was obvious to her. "The physicians are extremely uncomfortable treating you and do not find that they can do so in the physician-patient relationship that they would want to offer. Your past actions have made it difficult for them to accept you as a patient." The letter asked her to find a new physician within ten days and offered to make her case histories and other medical records available to her new physician.

The patient then filed suit for defamation against the clinic, its manager, and 23 of the physicians associated with it. A trial court dismissed the action against the physicians and later granted summary judgment for the clinic and its manager. The court also found the patient's claim frivolous and awarded the clinic \$7,611.00 in attorney's fees.

On appeal, the granting of summary judgment was affirmed. The court said the words used in the letter were "obviously innocent," did not constitute libel, and could not support the patient's defamation action. The court reversed the award of attorney's fees, however. Even though summary judgment was granted against the patient, there was not such a complete absence of fact or law that a reasonable person could not have thought a court would award judgment in her favor, the Supreme Court concluded. — *Moritz v. Medical Arts Clinic, P.C.*, 315 N.W.2d 458 (N.D.Sup.Ct., Jan. 19, 1982)

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Usage in Pregnancy Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

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Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

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References 1. Pitts NE, Migliardi JR: *Clinical Pediatrics* 13:87, 1974. 2. Modell W: *Drugs of Choice* 1980-1981. C. V. Mosby Co., St. Louis, 1980, p. 362. 3. Goodman LS, Gilman A: *The Pharmacologic Basis of Therapeutics*, 6th edition, MacMillan Publishing Co., Inc., New York, 1980, p. 1032.



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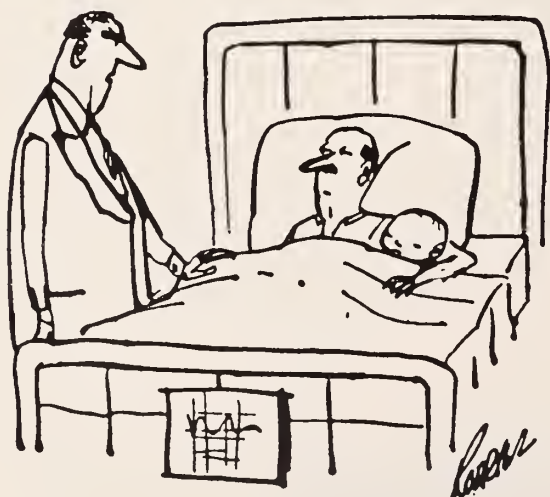
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PHYSICIAN completing radiology residency in June 1982 seeks location with private community hospital. Graduate of Harvard. Contact Dr. Eugene B. Rosenberg, Mount Sinai Medical Center, 4300 Alton Road, Miami Beach, FL 33140.

PHYSICIAN completing pathology residency in September 1982 seeks location with pathology group with emphasis on surgical pathology. Graduate of University of Tennessee School of Medicine. Contact Dr. William D. Crump, 1027-B Beacon Parkway East, Birmingham, AL 35209.

FAMILY PRACTICE resident seeks practice location in July 1983. Contact John D. Sites, M.D., 2002 Philip Dr., Muncie, IN 47302.

ANESTHESIOLOGIST seeks to relocate in state in solo, group or institutional practice. Contact M. T. Olivo, Jr., M.D., Box 794, Oxford, MS 38655.

BOARD ELIGIBLE PATHOLOGIST seeks practice opportunity. Graduate of University of Mississippi School of Medicine; residencies, UMC. Contact Marianna G. Pardue, M.D., 315 Cedarwood, Jackson, MS, 39212.

BOARD CERTIFIED FAMILY PRACTITIONER seeks practice location. Currently completing military obligation and available 7/82. Contact John E. Bailes, Jr., M.D., 5405 Hackney Circle, Bossier City, LA 71111.

OCCUPATIONAL HEALTH physician seeks position in industry or similar position. M.D. from University of Miami, 1962. Residency in internal medicine at Erlander Hospital, Chattanooga, and at UMC, Jackson. Contact: Gary LeBow, M.D., 202 Vail Avenue, #218, Homewood, AL 35209; (205) 942-0993.

SURGEON seeks location with established group in small city. Currently service as chief surgical resident at Ochsner Foundation Hospital. Available July 1983. Contact Thomas C. Kelly, M.D., 1516 Jefferson Highway, New Orleans, LA 70121.

CLASSIFIED

GENERAL SURGEON AND INTERNIST NEEDED. Rural, well-equipped, 50-bed hospital in Northeast Mississippi. Recently renovated. Offers fantastic opportunity for board certified or board eligible physician. Call or write Carson Wood, Administrator, Community Hospital of Calhoun County (601) 983-4321, P.O. Box 128, Pittsboro, MS 38951. (Other locations may be available.) A U.S. Health Corporation hospital.

MEDICAL DIRECTOR who is fully licensed and eligible or who can become eligible is needed at the Mississippi Department of Corrections, Parchman, Mississippi. Fringe benefits include life, health, disability, retirement, annual leave and sick leave accrued. The salary is negotiable. Please contact: Vanessa R. Long, M.S.S.W., Hospital Administrator, Mississippi Department of Corrections, Parchman, MS 38738; (601) 745-6611, Ext. 653.

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IN CONCLUSION

MSMA's Council on Scientific Assembly met last month to begin planning for the 115th Annual Session, May 11-15, 1983, at the Royal D'Iberville Hotel in Biloxi. Under the new Wednesday through Sunday format, the House of Delegates will meet on Thursday and Sunday mornings. Reference committees will meet on Thursday afternoon. Information about the schedule for scientific sections and special events, as well as the program for the MSMA Auxiliary Annual Session, will be announced in upcoming issues of Journal MSMA.

The first of the AMA's new Patient Medication Instruction sheets will be available some time this month. The program will develop and produce patient information material for distribution by physicians at the time drugs are prescribed, to supplement oral instructions. The PMIs will be prepared on single sheets bound into 100-sheet pads. The first PMIs will cover 20 drugs near the top of the list of the 100 most widely prescribed drugs, as published by the National Disease and Therapeutic Index.

Efforts to prevent and deter illicit use of cocaine will be intensified, due to statistics showing a fourfold increase in cocaine-related deaths, says the National Institute on Drug Abuse. Other statistics generating the priority attention to cocaine abuse are: the availability and increased prevalence among the 18- to 25-year-old group; a threefold increase in cocaine-related emergencies; and a sixfold increase in cocaine-related treatment program admissions between 1975 and 1981.

An AMA-supported bill requiring health insurance carriers to offer an option to extend coverage to a group policyholder's child from birth to the age of one year was signed by New York Gov. Hugh L. Carey. The coverage would include an initial hospital checkup, a predetermined number of well-child visits to a physician, screening and early detection service supervised and performed by a physician, and routine and necessary immunizations. It is believed the only state law requiring insurers to provide the option.

Six percent of Americans between the ages of 75 and 84 years and 20 percent of those older than 85 years are institutionalized, often for mental problems, in hospitals for the chronically ill or in nursing homes. In some of these patients, dementia stems from treatable medical problems, not brain damage, and can be reversed through careful diagnosis and treatment, according to Boston physicians writing in the July 16 issue of JAMA.

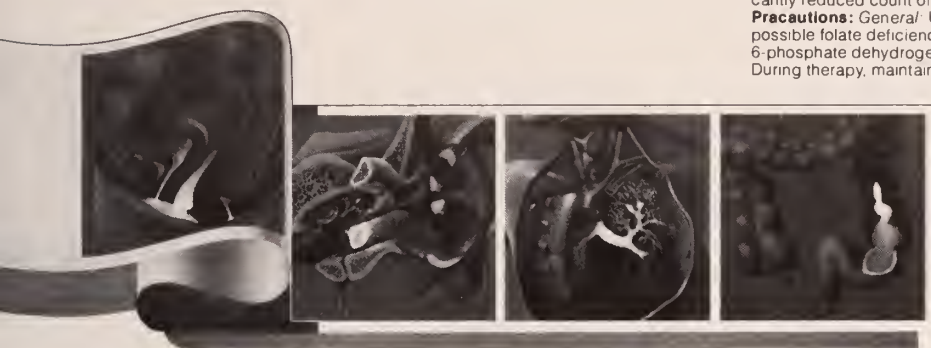
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BACTRIMTM (trimethoprim and sulfamethoxazole/Roche)
 Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonia.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides, patients with documented megaloblastic anemia due to folate deficiency, pregnancy at term, nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus, infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended, therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: General: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folate metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea, pseudomembranous colitis and pancreatitis. **CNS reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients, cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100, Tel-E-Dose[®] packages of 100; Prescription Packs of 20 and 28. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500, Tel-E-Dose[®] packages of 100, Prescription Packs of 40. Pediatric Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml), cherry flavored—bottles of 100 ml and 16 oz (1 pint). Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).



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1. Rubin RH, Swartz MN: *N Engl J Med* 303 426-432, Aug 21, 1980. 2. Data on file, Medical Department, Hoffmann-La Roche Inc.

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* due to susceptible strains of indicated organisms

Please see previous page for summary of product information.

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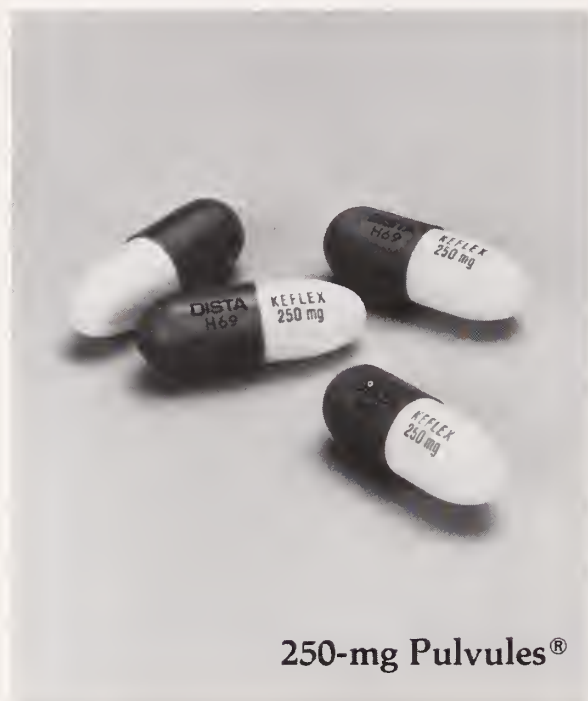
**Surgical Management of
Diverticular
Disease of the Colon**

**Review of a Modified Bristow
Procedure for Recurrent Anterior
Shoulder Dislocations**

**Radiological Seminar CCXXIV:
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CONTRAINDICATIONS

1) bronchial asthma, 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless it is secondary to a tachyarrhythmia treatable with propranolol, 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

WARNINGS

CARDIAC FAILURE In congestive heart failure, inhibition with beta-blockade carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. In patients already receiving digitalis, propranolol may reduce the positive inotropic action of digitalis and may have an additive depressant effect on AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, in rare instances, cardiac failure has developed during propranolol therapy. At the first sign of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and observed closely a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol should be immediately withdrawn, b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and closely followed until threat of cardiac failure is over

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of Inderal therapy. Therefore, when discontinuance of Inderal is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when Inderal is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Give special consideration to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Propranolol should be withdrawn slowly, since abrupt withdrawal may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol

IN PATIENTS UNDERGOING MAJOR SURGERY, beta-blockade impairs the ability of the heart to respond to reflex stimuli. Except in pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery. In case of emergency surgery the effects of propranolol can be reversed by administration of beta-receptor agonists such as isoproterenol or levaterenol, but such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has been reported

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g. CHRONIC BRONCHITIS, EMPHYSEMA), administer with caution, since propranolol may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta-receptors

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA Propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia, especially in patients with labile diabetes. A precipitous elevation of blood pressure may accompany hypoglycemic attacks

USE IN PREGNANCY Safe use in human pregnancy not established. Embryotoxic effects have been seen in animals at doses about 10 times the maximum recommended human dose

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if propranolol is administered, since it may occasionally produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension

Observe laboratory parameters at regular intervals. Use with caution in patients with impaired renal or hepatic function

ADVERSE REACTIONS

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, arterial insufficiency usually of the Raynaud type, thrombocytopenic purpura. **Central Nervous System:** lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. **Gastrointestinal:** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. **Allergic:** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. **Respiratory:** bronchospasm. **Hematologic:** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. **Miscellaneous:** reversible alopecia. Oculocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta-blocker (practolol) have not been conclusively associated with propranolol. **Clinical Laboratory Test Findings:** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase

HOW SUPPLIED

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Each hexagonal-shaped, orange, scored tablet is embossed with an 'I' and imprinted with 'INDERAL 10,' contains 10 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0421-81) and 1,000 (NDC 0046-0421-91). Also in unit dose package of 100 (NDC 0046-0421-99)

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Reference: 1. Freis, E. D. Hypertension (Suppl. II) 3:230 (Nov-Dec '81) 1981

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References: 1. Williams RL, Karacan I: Introduction, chap. 1, in *Sleep Disorders: Diagnosis and Treatment*, edited by Williams RL, Karacan I, Frazier SH. New York, John Wiley & Sons, 1978, p. 2. 2. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 3. Kales A et al: *JAMA* 241:1692-1695, Apr 20, 1979. 4. Kales A et al: *J Clin Pharmacol* 17:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. 5. Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 6. Kales A et al: *Clin Pharmacol Ther* 19:576-583, May 1976. 7. Kales A, Scharf MB, Kales JD: *Science* 201:1039-1041, Sep 15, 1978. 8. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 9. Dement WC et al: *Behav Med* 5(10):25-31, Oct 1978. 10. Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 11. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. 12. Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. 13. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 14. Kales A, Kales JD: *Pharmacol Physicians* 4(9):1-6, Sep 1970. 15. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

The Physician's Sleep Glossary

Some common sleep laboratory terms

poly·som·no·graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tone (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la·ten·cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af·ter sleep on·set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to·tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.¹

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.²

re·bound in·som·nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.³

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The efficacy of Dalmane has been studied in over 200 clinical trials with more than 10,000 patients.³⁻¹⁵ During long-term therapy, which is rarely required, periodic blood, kidney and liver function tests should be performed. Contraindicated in patients who are pregnant or hypersensitive to flurazepam.

Please see summary of product information on following page.



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Dalmane[®] (flurazepam HCl/Roche)

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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, light-headedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



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NEWSLETTER

September 1982

Dear Doctor:

The national health care systems in Canada and Great Britain are facing serious problems, according to recent news reports. The 600,000 employees enrolled in Britain's 12 health care unions demanded higher wages and took action forcing half of the country's hospitals to shut down except for emergency services. Canada's medicare system of free care for everyone is facing growing problems created by insufficient funding.

Government-imposed budgetary constraints are forcing many hospitals in Canada to ration their services, reduce beds, and freeze equipment services. The Canadian Medical Association is urging the government to provide more money, cautioning that the present level of funding risks quality and access.

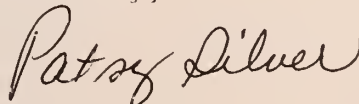
A recent NBC-TV report exaggerated the dangers of pertussis vaccine, a number of professional groups have charged. After viewing the show, a number of parents expressed concern about the DPT vaccine. The American Academy of Pediatrics says the program has eroded public confidence in the vaccine, and may decrease immunizations and increase the possibility of disease.

A steering committee representing medicine, government and industry has been assembled to begin an agenda process for developing a national health policy. The AMA initiated the process to replace the existing piecemeal approach to policy-making. The committee will meet again in January to review the progress of six work groups and an 80-member advisory committee.

A corporate fund-raising campaign was launched by the AMA Education and Research Foundation for its Patient Medication Instruction (PMI) program. Estimated first-year costs for the program are \$3.7 million. The PMI program will develop and produce patient information material for distribution by physicians at the time drugs are prescribed.

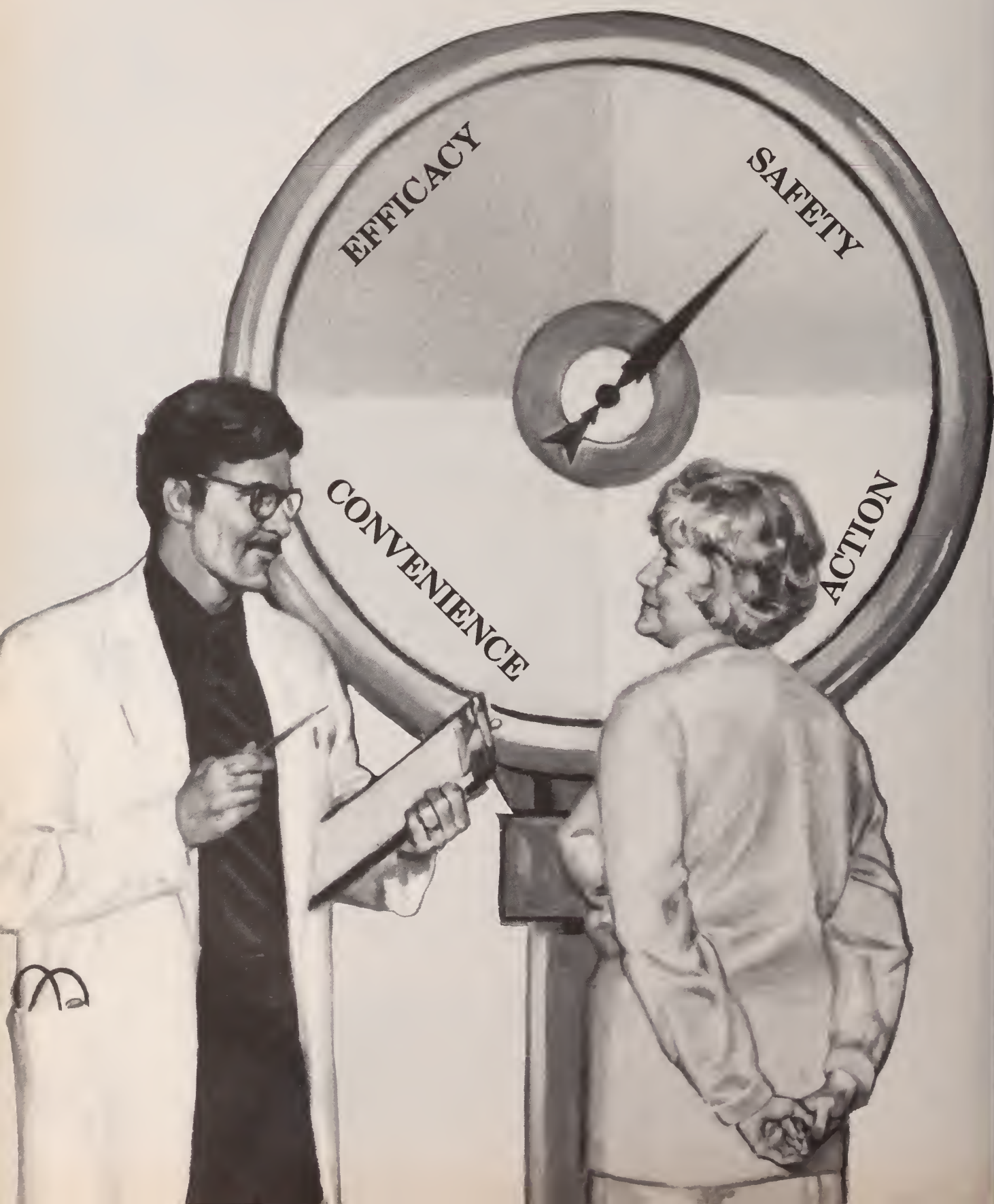
Over the next several months, MSMA will introduce a patient inquiry program throughout the state. The program, directed by the Board of Trustees and approved by the House of Delegates, will respond to patients' inquiries about physicians' services. The association's Committee on Peer Review will oversee the program, which will be staffed at MSMA headquarters in Jackson.

Sincerely,



Patsy Silver
Managing Editor

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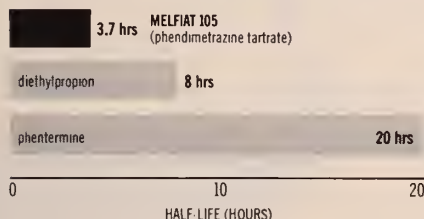
Because MELFIAT 105 effectively controls appetite.

MELFIAT 105 (phendimetrazine tartrate), an effective anorexiant, provides the appetite control overweight patients often need to begin a successful program of weight reduction. And the positive results of initial short-term therapy with MELFIAT 105 can help motivate them to a lifelong commitment of weight control.

Because MELFIAT 105 has a 3.7 hour half-life and low abuse potential.

Therapeutic efficacy combined with a short half-life and minimal abuse potential make MELFIAT 105 the drug of choice in the treatment of exogenous obesity. Because MELFIAT 105 has a short half-life, it minimizes drug accumulation and helps to eliminate such effects as disturbed sleep patterns. And, because MELFIAT 105 has significantly lower abuse potential than the amphetamines,¹ there's less risk to your patients. According to a NIDA (National Institute on Drug Abuse) report, phendimetrazine appears to be the least abused anorexiant when compared to phentermine and diethylpropion.²

Half-life comparison of MELFIAT 105 and other anorexiant²



Because MELFIAT 105 is in a sustained-release capsule.

MELFIAT 105 provides your patients with continuous drug delivery for appetite control that lasts throughout the day and helps to eliminate compulsive snacking and overeating at meals. In addition, the sustained-release capsule form maintains more constant blood levels of MELFIAT 105...without peaks and valleys.

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MELFIAT 105 is available in a convenient capsule containing 105 mg. The simple morning dosage regimen is designed to encourage compliance, minimizing the chance of missed doses and assuring optimum therapeutic results.

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References: 1. Sheu YS, Ferguson JA, Cooper JR: *Evaluation of the Abuse Liability of Diethylpropion, Phendimetrazine, and Phentermine*, unclassified document ADAMHA, HHS. Office of Medical and Professional Affairs, NIDA, 1980. 2. Douglas JG, Munro JF: The role of drugs in the treatment of obesity, *Drugs* 21:362-373, 1981.

MELFIAT® 105

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Sustained-Release Capsules 105 mg

MELFIAT® 105 UNICELLES® C

(phendimetrazine tartrate) 105 mg Sustained Release Capsules

INDICATIONS AND USAGE: Melfiat® 105 (phendimetrazine tartrate) is indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class (See CLINICAL PHARMACOLOGY) should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result).

WARNINGS: Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should be discontinued. Phendimetrazine tartrate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

Drug Dependence: Phendimetrazine tartrate is related chemically and pharmacologically to the amphetamines. Amphetamines and related stimulant drugs have been extensively abused, and the possibility of abuse of phendimetrazine tartrate should be kept in mind when evaluating the desirability of including a drug as part of a weight-reduction program. Abuse of amphetamines and related drugs may be associated with intense psychological dependence and severe social dysfunction. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high-dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG, manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia.

USAGE IN PREGNANCY: The safety of phendimetrazine tartrate in pregnancy and lactation has not been established. Therefore, phendimetrazine tartrate should not be taken by women who are or may become pregnant.

USAGE IN CHILDREN: Phendimetrazine tartrate is not recommended for use in children under 12 years of age.

PRECAUTION: Caution is to be exercised in prescribing phendimetrazine tartrate for patients with even mild hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of phendimetrazine tartrate and the concomitant dietary regimen. Phendimetrazine tartrate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdose.

ADVERSE REACTIONS: Cardiovascular: Palpitation, tachycardia, elevation of blood pressure.

Central Nervous System: Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache; rarely psychotic episodes at recommended doses.

Gastrointestinal: Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances.

Allergic: Urticaria.

Endocrine: Impotence, changes in libido.

OVERDOSAGE: Manifestations of acute overdose with phendimetrazine tartrate include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states.

Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma. Management of acute phendimetrazine tartrate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Acidification of the urine increases phendimetrazine tartrate excretion. Intravenous phenolamine (Regitine) has been suggested for possible acute, severe hypertension, if this complicates phendimetrazine tartrate overdose.

DOSAGE AND ADMINISTRATION: Since Melfiat® 105 (phendimetrazine tartrate) 105 mg is a sustained-release dosage form, limit to one sustained-release capsule in the morning. Melfiat® 105 (phendimetrazine tartrate) is not recommended for use in children under 12 years of age.

HOW SUPPLIED: Each orange and clear sustained release capsule contains 105 mg phendimetrazine tartrate in bottles of 100.

CAUTION: Federal law prohibits dispensing without prescription.



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DATELINE

Health Dept. Offers Jackson, MS - An updated list of Mississippi community
Fluoridation Info water supplies with fluoridation programs is available
 from the state health department. Physicians or others
may request a copy of this listing by contacting: Public Health Dentistry,
Mississippi State Department of Health, P.O. Box 1700, Jackson, MS 39205. Also
available upon request is a listing of all state community water supplies, their
fluoride content, and additional information on fluoridation.

Plan to Attend Jackson, MS - MSMA members are encouraged to mark their
Annual Session calendars now for the association's 115th Annual Session,
 set for May 11-15, 1983, at the Royal d'Iberville Hotel
in Biloxi. The Council on Scientific Assembly has arranged the special events
calendar to fit the new Wednesday through Sunday meeting format. Special guest
entertainer will be Mark Russell, nationally acclaimed political humorist. At
press time 12 of MSMA's 14 scientific sections had scheduled session dates.

Second Quarter Washington, DC - The physician's services component of the
CPI Figures CPI rose 7.8% in the second quarter of 1982, well below
 the all-items index, which rose by 11.0%. The hospital
room component increased at an even lower rate of 6.3% over the quarter. The
Dept. of Health and Human Services reported that Americans spent \$287 billion
on medical care last year, averaging \$1,225 per person. Of that amount, 42.8%
was spent by federal, state and local governments.

Committee Targets Jackson, MS - MSMA's Committee on Drunken Drivers has met
Drunken Drivers with representatives of various interested groups and has
 found that there is support for the effort to remove
drunk drivers from Mississippi roads and highways. The cooperative effort between
MSMA and these groups will likely result in a strong move to strengthen the
implied consent law during the upcoming session of the legislature and possibly a
recommendation that legal age for purchase of beer be increased from 18 to 21.

Cancer Patient Bethesda, MD - Parents of children with cancer may benefit
Handbook Available from a 93-page booklet available from the National Cancer
 Institute. Young People With Cancer: Handbook for Parents
provides basic information on cancer and its treatment. It also discusses psycho-
social aspects of the disease which may affect the child and the entire family.
Physicians or parents may order the free booklet by writing the National Cancer
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DESCRIPTION VERMOX (mebendazole) is methyl 5-benzoylbenzimidazole-2-carbamate.

ACTIONS VERMOX exerts its anthelmintic effect by blocking glucose uptake by the susceptible helminths, thereby depleting the energy level until it becomes inadequate for survival. In man, approximately 2% of administered mebendazole is excreted in urine as unchanged drug or a primary metabolite. Following administration of 100 mg of mebendazole twice daily for three consecutive days, plasma levels of mebendazole and its primary metabolite, the 2-amine, never exceeded 0.03 µg/ml and 0.09 µg/ml, respectively.

INDICATIONS VERMOX is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (common roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections. Efficacy varies as a function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Whipworm	Common Roundworm	Hookworm	Pinworm
cure rates				
mean	68%	98%	96%	95%
(range)	(61-75%)	(91-100%)	—	(90-100%)
egg reduction				
mean	93%	99.7%	99.9%	—
(range)	(70-99%)	(99.5%-100%)	—	—

CONTRAINDICATIONS VERMOX is contraindicated in pregnant women (see Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

PRECAUTIONS PREGNANCY: VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

ADVERSE REACTIONS Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

DOSAGE AND ADMINISTRATION The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time. For the control of common roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days. If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

HOW SUPPLIED VERMOX is available as chewable tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets. VERMOX (mebendazole) is an original product of Janssen Pharmaceutica, Belgium.

US Patent 3,657,267
December 1979

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ORIGINAL PAPERS

Surgical Management of Diverticular Disease of the Colon

WILLIAM O. BARNETT, M.D.
Jackson, Mississippi

ALONG THE ALIMENTARY TRACT, the most common site for diverticulum formation is the colon. The descending and sigmoid portions are most often involved (see Figure 1).¹ Although diverticula may occur in any part of the colon, they may be seen throughout the entire colon in some cases. They are nearly always acquired and are seen predominately in middle or old age. These are false diverticula and represent herniations of the mucosa through muscle defects in the colon wall, usually where the segmental arteries pass through (see Figure 2).²

True diverticula of the colon occur but are uncommon. They are composed of all layers of the bowel wall and are congenital. True diverticula are located almost exclusively in the right colon near the ileocecal valve. If they become symptomatic, it usually occurs during adolescence or early life.

The term diverticulosis is generally used to denote the presence of diverticula unattended by inflammatory change. Precise definition of the presence or extent of inflammation is very difficult in some cases so that a "gray" zone exists and complicates a distinction between diverticulosis and diverticulitis. Therefore, most authors have adopted the term diverticular disease, which is all inclusive and eliminates the need to venture toward an exercise in inexactness. Symptoms resulting from diverticulosis are minimal and necessitate treatment only to a limited degree except for hemorrhage. It is generally held that the uninflamed diverticulum is more likely to give rise to significant colon bleeding.



Figure 1. Colon diverticula are best demonstrated during barium enema x-ray examination.

Acute Diverticulitis

Quiescent diverticula become symptomatic when functional obstruction of the neck occurs, as with an entrapped fecalith. Inflammatory changes develop which may erode the mucosa and spread through the layers of the bowel wall. Symptoms which are man-

From the Department of Surgery, Mississippi Baptist Medical Center, Jackson, MS.

ifested by this process include abdominal pain, fever and possible accentuation of either constipation or diarrhea. Abdominal tenderness also attends these developments, and it usually is located in the left lower quadrant. Barium enema examination is very helpful in making the diagnosis as well as defining the extent of the disease. It is usually wise to postpone this study until after the inflammatory changes have subsided to some extent. Ill-timed, overly aggressive x-ray studies may produce colon perforation and convert a limited problem into a surgical emergency.

In the management of this condition, rest of the alimentary tract should be encouraged by eliminating oral intake and initiating naso-gastric suction. Intravenous fluids and electrolytes are employed along with parenteral antibiotics. Our current preference is Mandol with the addition of an aminoglycoside in more advanced cases. With this regimen, all symptoms may completely disappear and in some cases no future exacerbation of diverticular disease occurs. In other instances it may be necessary to resort to elective colon resection. Additional indications for surgical intervention include localized abscess, diffuse peritonitis, fistula, obstruction and hemorrhage (see Figure 3).

Elective Resection

The mortality rate for elective colon resection in most major centers has declined to approximately 2%. This figure is considerably superior to that achieved when operation is carried out under emergency conditions. The difference in mortality between elective and emergency operation in diverticulitis has led many gastroenterologic surgeons to urge earlier elective resection under certain circumstances. Elective resection should be strongly considered in patients who experience two or more attacks of diverticulitis as evidenced by fever, left lower quadrant abdominal pain and tenderness and lasting several days. When diverticulitis occurs in patients under 50 years of age, elective resection should be supported. It is also advisable in patients manifesting urinary tract symptoms because this suggests adherence of the colon to the bladder with possible impending development of colovesical fistula. Additional findings favoring elective resection include a persistent palpable mass, narrowing of the colon on x-ray and inability to differentiate the lesion from carcinoma.

Surgical Hazards

In my own experience, more patients with serious complications are referred following surgical proce-

dures for diverticular disease than for any other colon condition. Anastomotic leakage is not uncommon, and this is a result of the poor quality of the colon which must be utilized if permanent colostomy is to be avoided. The following considerations serve to enhance the challenge.

Adherent Small Bowel — Once the abdomen is opened, it is usually immediately apparent that the small bowel is intimately and firmly adherent to the inflamed colon as well as to the surrounding structures. Indeed, this state of small bowel adhesions may be such that obstruction of the ileum or jejunum represents the presenting or an additional pathological process. The small bowel must be completely mobilized and retracted from the path of harm before the abnormal colon can be resected. Opportunities for untoward technical mishaps are afforded here and include hemorrhage, inadvertent opening of the small bowel, and devascularization resulting from injury to vessels during dissection of the adherent mesentery. Postoperative small bowel fistula may appear as a result of insecure closure of an injury under adverse circumstances.

Ureteral Injury — The left ureter is especially vulnerable during dissection because of the common involvement of the sigmoid colon. Experience and familiarity with the relation of the ureter to the colon and other adjacent structures serve the operator well during this exercise. It is best to identify and specifically avoid the ureter during each application of clamps. When attempts to identify the ureter meet with failure, a measure of safety can be gained by clamping the mesentery close to the bowel, a maneuver which is acceptable because of the non-malignant nature of the condition.

Small Colon Lumen — Reduced colon circumference and narrowing of the bowel lumen characteristically accompany diverticular disease of the colon. This affords a hazard which is not seen during anastomosis of the normal colon, as is usually available following resection for carcinoma. The surgeon is compelled to attempt to achieve a leak-proof anastomosis with preservation of an adequate lumen. This goal is more difficult to accomplish in segments of the alimentary tract with a small diameter.

Thick, Rigid Colon Wall — The colon afflicted by diverticular disease characteristically exhibits hypertrophy and hyperplasia of the circular and longitudinal muscle coats. These changes result in extensive thickening of the colon wall. Also, the surgeon finds the wall to be rigid, unyielding and more friable. Attempts to employ intraluminal stapling devices under these circumstances are apt to be attended by splitting and tearing of the colon wall.

RELATION OF DIVERTICULA TO COLON WALL STRUCTURES

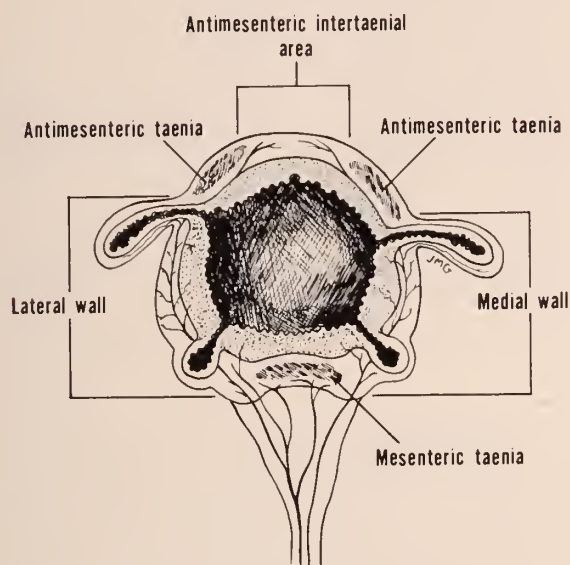


Figure 2. Anatomical characteristic of colon diverticula.

Application of the serosal layer of sutures frequently is accomplished by cutting or tearing through the bowel wall, excessive suture line tension and the infolding of more bowel wall than is desirable, with further compromise of the lumen. All these characteristics, of course, contribute to an increased risk of anastomotic leakage.

Shortened Colon — The aforementioned muscle changes along with contraction of the taenia coli are responsible for shortening and pleating of the colon which is usually present in diverticular disease. This, too, contributes to the likelihood of anastomotic leakage because inadequate colon length may result in anastomotic tension. These changes, for some unknown reason, most commonly involve the descending and sigmoid colon. A degree of mobilization of the sigmoid colon can be achieved by freeing of the inflammatory mass and division of the lateral peritoneal reflection. At this stage it is usually discovered that the rectosigmoid is not involved or only to a minimal degree. Anastomotic advantages provided by these circumstances can be further enhanced by the freeing of the usually normal rectum from the hollow of the sacrum. Thus, a relatively favorable distal bowel segment can usually be dissected free and made available for anastomosis.

Upon turning one's attention to the proximal bowel, after resection of the abnormal sigmoid colon, the descending colon is frequently found to be

COMPLICATIONS OF COLON DIVERTICULITIS

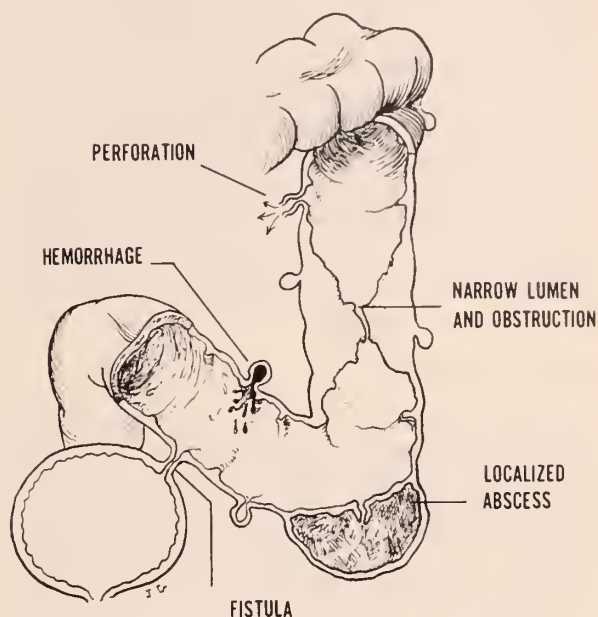


Figure 3. Serious problems which may result from colon diverticula.

taut and of small caliber. In contrast, the transverse colon characteristically is much less involved, is generously redundant, has a relatively soft and pliable wall and an ample lumen. These attractive features have motivated me, with increasing frequency, to employ the left transverse colon for anastomosis to the distal rectosigmoid stump. The splenic flexure of the colon is mobilized, the descending colon is removed up to a point where good quality colon is reached and the transverse colon is swung down and anastomosed to the distal segment.

Remaining Diverticula — The not-unusual extensive colon involvement with diverticula is well known and is constantly demonstrated by barium enema examination. During colon anastomosis, the surgeon must be ever alert to avoid including a non-symptomatic diverticulum in the line of anastomosis. This occurrence would provide a vulnerable point where only mucosa with no muscle support would be responsible for maintaining the integrity of the anastomosis. Thus, the likelihood of leakage would increase.

Unsuspected Carcinoma — Perforated carcinoma of the sigmoid colon may mimic diverticulitis where pre-operative studies have not been possible. Radio-

graph findings, which may possibly represent carcinoma, also necessitate a decision as to whether a cancer type resection should be employed initially. In my experience, if there are no unequivocal signs of malignancy, such as liver metastasis or peritoneal implants then the best plan is to separate the colon from adherent organs and tissues. The involved colon is resected and opened. A malignant lesion arising from the mucosa will be readily apparent while the absence of mucosal involvement represents good evidence for an inflammatory lesion. Frozen section examination can be employed in those cases where the diagnosis continues to remain in doubt.

Colon Perforation

The most common major complication of diverticulitis is perforation of the colon. This may be followed by effective containment of an abscess or a diffuse, spreading peritonitis. The former is usually attended by abdominal pain, tenderness, fever and a mass in the left lower abdominal quadrant. Antibiotic administration, along with intravenous fluids and electrolytes, is employed. Operative intervention is indicated. The procedure of choice is resection of the abnormal colon including the site of perforation.³ The distal colon is stapled closed, and the proximal bowel is fashioned into an end colostomy. Eight to twelve weeks later the colostomy can be dismantled with re-establishment of colon continuity (see Figure 4).

Patients with a perforated colon and spreading peritonitis are sicker and necessitate earlier operative intervention. The abnormal colon is removed and a colostomy is established as described above. Extensive peritoneal irrigation with warm isotonic saline is beneficial. The majority of surgeons believe that primary colon anastomosis carried out in the presence of colon perforation is dangerous.

Fistula

In colon diverticular disease, fistulization occurs most often with the skin or the bladder. A colocutaneous fistula may be demonstrated by injection contrast material through the skin opening and then demonstrating its presence within the colon. Colovesical fistula presents with pneumaturia or fecaluria or both. Confirmatory evidence may be obtained with cystoscopy and cystogram. It is uncommon to be able to demonstrate the fistula by barium enema. Most fistulae arising from colon diverticula can be resected successfully in one stage, with the occasional case necessitating multiple, staged procedures.

MANAGEMENT OF PERFORATED COLON IN DIVERTICULITIS

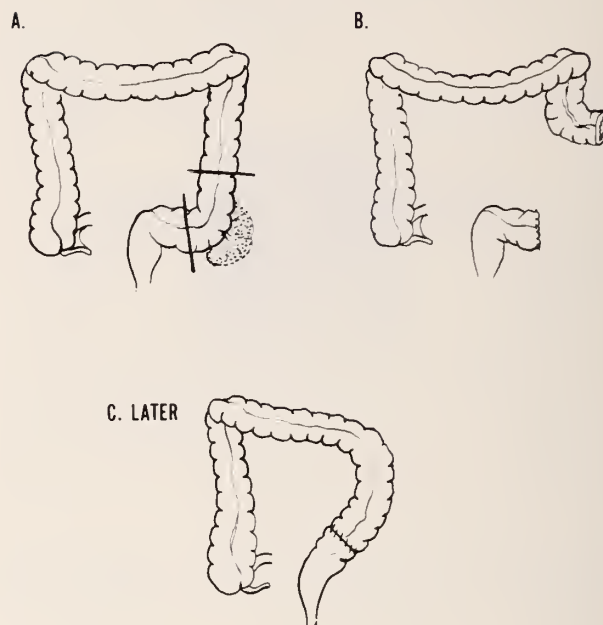


Figure 4. Removal of the diseased colon segment is highly desirable.

Obstruction

Recurring diverticulitis and scar tissue formation over the years can produce complete colon obstruction. It is usually seen on the left side and is certainly a less frequent cause of obstruction of the colon than is carcinoma. Immediate relief of the obstruction should be provided by a totally diverting transverse colostomy. Later, the altered colon can be removed with closure of the colostomy.

Intestinal obstruction also may result from adherence of the small bowel to an inflammatory mass of diverticulitis-origin. This clinical picture, of course, is one of small bowel obstruction. Operative relief is usually necessary and consists of dissection of the small bowel and freeing it from the inflammatory mass. The altered colon segment should then be resected with closure of the distal portion and the establishment of a proximal colostomy. Colon continuity can be re-established at a later date.

Hemorrhage

Diverticula account for a major portion of cases evidencing massive rectal bleeding. This is probably

related to the fact that mucosal herniation through the colon wall usually occurs where the segmental artery passes through the muscle. The neck of the diverticulum is therefore in close proximity to a sizeable artery. Hemorrhage occurs in patients with diverticulosis and virtually never is it seen in diverticulitis. The diagnosis is usually made by selective angiography of both the superior and inferior mesenteric arteries. In poor risk patients, Pertussin infusions may be tried. Where bleeding persists after the infusion of five units of blood, surgical intervention should be strongly considered. The procedure of choice is subtotal colectomy with anastomosis of the ileum to the rectosigmoid.⁴

Summary

Colon diverticula are of the false variety and usually involve the descending and sigmoid portions. Diverticulosis is common, extensively involves the colon and is virtually asymptomatic, except for hemorrhage. Diverticulitis results from impaired drainage and produces pain, fever and abdominal tenderness. Antibiotics and alimentary tract

rest should be employed in the early management. Elective colon resection carries a low mortality rate in modern medical centers. It should be employed for patients who have two or more attacks or are under 50 years of age or where urinary symptoms are present. Colon resection for diverticular disease can be hazardous because of adherent small bowel, possible uretral injury, small size of colon lumen, thick rigid colon wall, shortened colon, remaining diverticula and unsuspected carcinoma. Serious complications include colon perforation, fistula, obstruction and hemorrhage. ★★★

References

1. Rodkey, G. V. and Welch, C. E.: Colon diverticular disease with surgical treatment. *Surg. Clin. N. Am.* 54:655, 1974.
2. Goligher, J. C.: *Surgery of the Anus, Rectum and Colon.* London, Bailliere Tindall, 1980, p. 902.
3. Eng, K., Rawson, J. H. and Localio, S. A.: Resection of the perforated segment in diverticulitis. *Am. J. Surg.* 133:67, 1977.
4. Zollinger, R. M.: *General Surgery Principles in Practice.* Le Jacq, 1981, p. 85.

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Review of a Modified Bristow Procedure For Recurrent Anterior Shoulder Dislocation

GENE R. BARRETT, M.D., WILLIAM B. DIAL, M.D., and WILLIAM B. EVINS, M.D.

RECURRENT ANTERIOR SHOULDER dislocation or subluxation is a major problem, especially to the athletically oriented individual.² Since nonoperative methods are usually unsuccessful, one must rely on the surgical treatment of this problem. Because the glenohumeral joint is such a shallow joint, it allows for a remarkable range of motion. This range of motion, especially abduction and external rotation, is essential in most sports. Stability of the joint comes from the rotator cuff mechanism, while the extremely lax capsule allows for the needed range of motion.

The mechanisms of injury producing anterior dislocation are several:⁹

1. Hyperextension of an abducted arm,
2. Excessive external rotation of the arm in abduction,
3. A direct blow to the posterior aspect of the shoulder.

With anterior dislocation, the humeral head dislocates anteriorly and inferiorly. This produces attenuation of the thin anterior capsule, and subsequent dislocations cause the capsule to become so loose and attenuated that a large anterior recess occurs. In the natural history of the process a detachment of the glenoid labrum or Bankart lesion and, in many patients, a bony defect consisting of flattening of the posterior-lateral aspect of the humeral head, or Hill-Sachs lesion, is noticed.¹ It has been postulated that both of these lesions predispose to recurrent dislocation.

The initial dislocation is traumatic in 94-96% of cases.³ With each subsequent dislocation there is progression of the alteration of the capsule, ligaments, glenoid labrum, and the humeral head as described. Four to six per cent of dislocations are atraumatic. Because of the initial laxness necessary for atraumatic dislocation, these cases tend to re-dislocate much more easily.¹

There are numerous procedures available that have been described to treat recurrent anterior dislocation of the shoulder.⁶ Most of these have limitation of external rotation of the humerus in common. Some involve ligament reconstruction or tendon checkrein mechanisms. The essential element of most is that the subscapularis insertion is altered and massive scar formation occurs anteriorly about the joint, thereby limiting shoulder motion.

In an effort to improve our results with shoulder motion, especially in our athletic patients, we turned to the Bristow procedure.⁴ This procedure was first described by Helfet in 1958,⁵ in memory of Dr. W. Rowley Bristow, of South Africa, who originated the procedure in 1949. The procedure consists of transfer of the distal 1.5-2 cm of the coracoid with the conjoint tendon of the short head of the biceps and coracobrachialis to the anterior inferior aspect of the scapular neck just medial to the glenoid rim. Bristow originally secured the transplanted coracoid to the scapular neck by suturing the conjoint tendon to the edges of the longitudinally cut subscapularis muscle. The transfer thereby creates a sound buttressing effect to the weak anterior capsule. This effect is increased in the position of vulnerability (abduction and external rotation) because the short head of the biceps and the coracobrachialis are drawn firmly across the anterior inferior portion of the capsule, thus reinforcing it.

There have been several modifications of the procedure since its inception in 1949.⁷ In 1970 May used a screw for fixation of the coracoid and divided

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Presented at the Combined North Carolina-South Carolina State Orthopedic Meeting, 1977.

the subscapularis both longitudinally and transversely.⁸ The inferior half of the subscapularis was passed beneath the transferred conjoint tendon and then plicated at its distal end with the humerus in internal rotation.

Clinical Material

At the Greenville Hospital System, Greenville, South Carolina, between September 1972 and January 1977, we performed 50 modified Bristow procedures on 49 patients. There were 45 males and four females. The age ranged from 15-41 years with an average of 23.7 years. Thirty-six of the dislocations occurred during athletic activities at two neighboring universities, 12 occurred in automobile accidents, and 2 were secondary to grand mal seizure disorders.

Technique

The technique used was very similar to that used by Collins and Wilde in 1973. An anterior deltoid incision is made. The deltopectoral groove is identified and a small portion of the deltoid muscle is retracted medially with the cephalic vein. The coracoid is then exposed and a 9/64 inch drill hole is placed in its tip. The distal 1.5-2 cm of coracoid is resected using an osteotome, being careful not to splinter the tip. The conjoint tendon is then isolated gently as far as the entrance of the musculocutaneous nerve. The subscapularis is then exposed as it crosses the scapular neck. A longitudinal incision is made in its tendon at the junction of the middle and distal thirds. The capsule is exposed, incised, and the joint is explored. Exposure of the scapular neck is performed by reflecting the subscapularis with an elevator and then a 2 cm area of cortex is roughened up. A 7/64 inch drill hole is placed through the scapular neck just proximal to the glenoid rim in the inferior one third. A screw is used for fixation of the coracoid. Finally the edges of the subscapularis are approximated.

FIGURE 1
RESULTS

Limitation of ROM	
Excellent (15 Lack Ext. Rot.)	33
Good (25 Lack Ext. Rot.)	11
Poor (25 Lack Ext. Rot.)	1
Lost to Follow-up	1
No ROM Recorded	2
Failures (recurrence)	2
6 Patients lacked 5°-10° of Abduction	
1 Patient lacked 20° of Abduction	

Postoperative Routine

From 1972 to 1975 we performed 26 procedures. The vast majority of these were college athletes. They were immobilized postoperatively in a velpeau dressing and then after 2 to 4 days were placed in a plaster yoke. Since 1975 our patients have been placed in a sling and swathe immediately following surgery and maintained.

The postoperative regimen for our athletic patients was as follows:

- 1. Immobilization 4 weeks
- 2. Forearm curls
Circumduction exercise 4 weeks
(sling when not exercising)
- 3. Bench presses 6 weeks-8 weeks
- 4. General military press
Swimming 10 weeks
- 5. Return to full activity 12 weeks
(Athletics)

The non-athletic patient followed a similar regimen of 4 weeks of immobilization progressing to full activity at 3 months.

Results

Our follow-up ranged from 1 to 36 months with an average of 6.7 months. Thirty-three of our 50 patients obtained an excellent result, defined as a lack of less than 15 degrees of external rotation. Eleven patients obtained a good result, defined as a lack of less than 25 degrees of external rotation. One patient lacked greater than 25 degrees of external rotation. Six patients lacked from 5 to 10 degrees of abduction, while one patient lacked 20 degrees of abduction. Only one of our patients was completely lost to follow-up. No accurate range of motion was recorded on two patients in the clinic charts, but the range of motion was described as full (see Figure 1).

In our 50 patients we had only 2 recurrences. One was in a middle-aged female with a grand mal seizure disorder and bilateral recurrent shoulder dislocation. She had had bilateral Putti-Platt procedures followed by bilateral modified Bristow procedures. Her left shoulder continues to dislocate. Our other recurrence was in a young male with brachial plexus injury on the same shoulder as his modified Bristow procedure. He discontinued the immobilization himself at two weeks and has dislocated four times since.

In our series we had 70% excellent and 22% good results for a total of 92% satisfactory shoulders. We

FIGURE 2
RESULTS

70% Excellent	
22% Good	92% Satisfactory
4% Recurrence	
2% Poor ROM	6% Unsatisfactory
2% Lost to Follow-up	

FIGURE 3
COMPLICATIONS

1. Loss of position of screw
 2. Coracoid split intra-operatively
 3. Recurrences
 - One GMDS
 - One brachial plexus injury
(immobilized only 2 weeks)
- No musculocutaneous nerve injury or infections

had 3 patients with either a poor range of motion or a recurrence for a total of 6% unsatisfactory results (see Figure 2). No patient had significant pain beyond the immediate post-op period except one. In this patient the screw fixation was lost. Upon exploration the bone block was not united. The screw was removed and the bone block was not disturbed. The patient went on to adequate range of motion and complete pain relief. In one other patient the coracoid was split intraoperatively. Screw fixation was used in spite of this and the patient has an excellent range of motion. We had no musculocutaneous nerve injuries or wound infections. One of our patients, a high school baseball pitcher, could not return to his pre-op level of proficiency despite an adequate range of motion on examination (see Figure 3).

Conclusion

After reviewing 50 cases of the modified Bristol arthroplasty, we feel that the procedure offers an

excellent means of surgical treatment for recurrent anterior shoulder dislocation. When used in patients with normal musculature, it offers shoulder stability with little loss of range of motion. However, patient selection is an extremely important aspect of the treatment of shoulder dislocation with this procedure. We do not recommend the procedure in epileptic patients, or patients with other complicating factors such as our patient with the brachial plexus injury. We feel that our two recurrences were due to poor patient selection rather than the type of surgery selected. All of our athletic patients returned to their pre-operative level of proficiency except the one baseball player. In spite of an adequate range of motion he could not return to pitching.

The Bristow procedure as modified offers ease of technique, stability of the recurrent dislocating shoulder, and good range of motion in the properly selected patient. ★★★

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References

1. Calandriello, Brono: The pathology of recurrent dislocation of the shoulder. *Clinical Orthopedics*, Vol. 20, 1961.
2. Collins, H. Roger and Wilde, Alan H.: Shoulder instability in athletics. *Orthoped. Clin. N. Am.* 4:759-774, July 1973.
3. Haley, Philip H. and House, James H.: Recurrent anterior dislocation of the shoulder. *Minn. Med.* 882-885, November 1974.
4. Halley, David K. and Olix, Melvin L.: A review of the Bristow operation for recurrent anterior shoulder dislocation in athletes. *Clin. Orthoped. & Related Res.* 106:175-179, February, 1975.
5. Helfet, Arthur J.: Coracoid transplantation for recurring dislocation of the shoulder. *J. Bone & Joint Surg.* 40-B:198-202, May, 1958.
6. Lipscomb, A. Bryant: Treatment of recurrent anterior dislocation and subluxation of the glenohumeral joint in athletes. *Clin. Orthoped. & Related Res.* 109:122-125, June 1975.
7. Lombardo, Stephen J., Kerlan, Robert K., Jobe, Frank W., Carter, Vincent S., Blazina, Martin E., and Shields, Clarence L., Jr.: The modified Bristow procedure for recurrent dislocation of the shoulder. *J. Bone & Joint Surg.* 58-A (No. 2):256-261, March 1976.
8. May, Virgil R.: A modified Bristow operation for anterior recurrent dislocation of the shoulder. *J. Bone & Joint Surg.* 52-A:1010-1016, July 1970.
9. Rowe, Carter R.: Acute and recurrent dislocation of the shoulder. *J. Bone & Joint Surg.* 44-A:998-1008, 1962.

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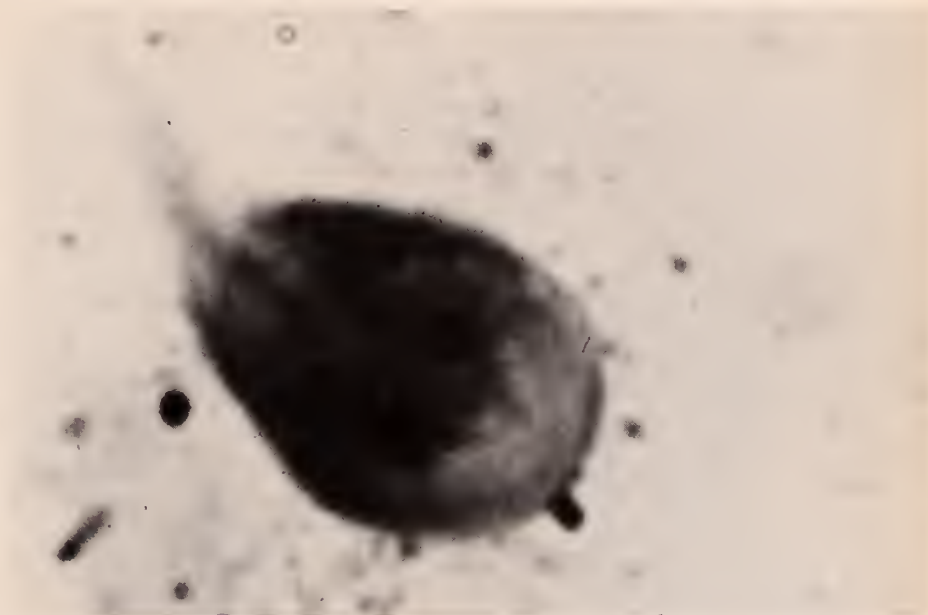
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REFERENCES

1. Babb, R.R., Beal, C.B., Use of a Duodenal Capsule for Localization of Upper Gastrointestinal Hemorrhage, GUT 15:492, 1974.
2. Beal, C.B., et al., A New Technique for Sampling Duodenal Contents, Am. J. Trop. Med. & Hyg. 19:349, 1970.
3. Bezjak, B., Evaluation of a New Technique for Sampling Duodenal Contents in Parasitologic Diagnosis, Am J Dig Dis 17:845, 1972.
4. Mahmoud, AAF., Warren, K.S.: Algorithms in the Diagnosis and Management of Exotic Diseases II. Giardiasis, J. Infect. Dis. 131:621, 1975.
5. Thomas, G.E., et al: Use of the Entero-Test Duodenal Capsule in the Diagnosis of Giardiasis, S. Afr. Med. J. 48:2219, 1974.
6. Kuberski, T.T., et al: Disseminated Strongyloidiasis, West. J. Med. 122:504, 1975.
7. Gilman, R.N., Hornick, R.B: Duodenal Isolation of Salmonella typhi by String Capsule in Acute Typhoid Fever, J. Clin. Microbiol. 3:456, 1976.
8. Benavente, L., Gotuzzo, E., Guerra, J., et al: Diagnosis of Salmonella typhi by culture of duodenal string capsule, N. Engl. J. Med. 304:54, 1981.
9. Colon, AR: Sampling of Duodenal Contents by a Nylon Line, J. of Peds., 89:513, 1976.
10. Gracey, M., Suharjono, Sunoto: Use of a Simple Duodenal Capsule to Study Upper Intestinal Microflora, Arch. Dis. Child 52:74, 1977.
11. Baron J.H: The clinical use of gastric function tests, Scand. J. Gastroent. Suppl. 6:9, 1970.
12. Rosenthal, P., Liebman, W.M: Comparative Study of Stool Examinations, Duodenal Aspiration, and Pediatric Entero-Test for Giardiasis in Children, J. Pediatr. 96:278, 1980.
13. Liebman, W.M., Rosenthal, P: The string test for gastroesophageal reflux, Am. J. Dis. Child 134:775, 1980.



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Radiological Seminar CCXXIV: Radionuclide Cerebral Angiography and Brain Death

JAMES L. BURKHALTER, M.D. and BHARTI R. PATEL, M.D.
Jackson, Mississippi

RADIONUCLIDE ANGIOGRAPHY, utilizing a scintillation gamma camera in combination with data acquisition by computer, was performed in two patients in their early twenties. Absence of cerebral blood flow was documented. This study can be utilized for demonstrating lack of cerebral blood flow in patients who are diagnosed to have brain death on clinical examination and EEG evaluation. It is a rapid, reliable, and easily performed test which can be a valuable aid in confirming the diagnosis of cerebral death.

Case 1

The first patient was a young female who presented to the UMC emergency room after an acute onset of unconsciousness followed by a mild right hemiparesis and expressive dysphasia. CT scan revealed hemorrhage in the left sylvian fissure with slight ventricular effacement. Arteriography revealed an aneurysm at the bifurcation of the left internal carotid artery with associated vasospasm. The patient's condition deteriorated, and two days later she experienced a cardiopulmonary arrest. Following resuscitative efforts, a CT scan of the brain revealed further hemorrhage in the left cerebral hemisphere and evidence of herniation of cerebellar tonsils. Neurological examination was consistent with brain death; EEG revealed no cerebral electrical activity. A rapid sequence radionuclide cerebral blood flow study was obtained which revealed no intracranial arterial flow (see Figure 2a). A blood pool image, obtained two minutes after injection, demonstrated no activity in the venous sinus (see Figure 2b). An intravenous dose of 20 mCi of ^{99m}technetium glucoheptonate was used for the study; 15 cc normal saline was used for flushing the dose to assure good bolus injection.

Case 2

The second patient was a motor vehicle accident victim transferred to UMC with multiple injuries, arriving in a comatose state with no cephalic reflex activity. CT scan of the head after emergency laparotomy and craniotomy revealed significant cerebral edema with evidence of subarachnoid hemorrhage. On clinical examination, diagnosis of brain death was made. A radionuclide cerebral flow study revealed no intracranial blood flow (see Figure 3a), and immediate static image of the brain failed to reveal any sagittal sinus activity (see Figure 3b). The procedure of rapid sequence blood flow study was the same as on the previous case.

Discussion

The National Institute of Neurological and Communicative Disorders and Stroke proposed that a confirmatory test related to cerebral blood flow be carried out in all cases in which an early decision of cerebral death is needed.¹ Cardiopulmonary arrest has classically been used as the criterion for death; with changes in societal attitudes on death and in available medical treatment including prolonged mechanical life support, "brain death" has become a widely used and recognized term.² The actual term "cerebral death" implies a state of irreversible destruction of virtually the entire brain despite continued cardiac activity.³ Although clinical findings in the appropriate setting are classical and include absence of cerebral responsiveness to any form of external stimulation, absence of respiratory activity and brain stem reflexes, confirmatory tests are often helpful.⁴ A flat EEG is classical for, but may not be of any help in confirming the diagnosis of brain death in patients with drug intoxication or hypothermia, since cases of CNS recovery after flat EEG secondary to medication-induced coma are well documented.³ Barbiturate overdose is one common cause of this. Another accepted finding in brain

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, University Medical Center,
Jackson, MS.

death is absence of intracranial blood flow in a patient with the appropriate clinical criteria; contrast cerebral angiography documented this by revealing the flow of contrast in the internal carotid artery abruptly terminating at the base of the skull with non-visualization of the intracranial circulation.⁶ The same objective findings can be obtained by doing a radionuclide cerebral angiogram at less cost and stress to the family and, in some hospitals hav-

ing a mobile scintillation camera, without having to move the patient from his area of intensive supportive care to the angiography suite.^{2, 6}

The technique used in our hospital involves the primary physician having made the clinical evaluation of cerebral death and his consulting the nuclear medicine division for a confirmatory radionuclide cerebral angiogram. A gamma camera is utilized for the study, and computer acquisition of data is also

Figure 1. (a) Normal anterior cerebral radionuclide flow study, with bilateral carotid and middle cerebral arteries as well as the anterior cerebral group being demonstrated; and (b) Normal anterior blood pool image with activity seen in the dural sinuses.



Figure 2. (a) Absence of activity in the cerebral arteries; and (b) Absence of activity in the dural sinuses on the static blood pool image.



Figure 3. (a) Absence of activity in the cerebral arteries, with some activity seen in the scalp vessels; and (b) Absence of activity in the dural sinuses on the static blood pool image.



done. Since all of our routine radionuclide brain scans include an anterior flow study, the cerebral blood flow study is done routinely. When the cerebral blood flow study is done to confirm cerebral death, 15 cc normal saline flush is utilized to assure a good bolus injection. A 2 minute anterior blood pool image is also obtained routinely when the study is done to evaluate possible cerebral death. In order to minimize the amount of radiotracer entering the scalp circulation and thus confusing the cerebral flow study, one can apply a tourniquet around the patient's scalp.² The difference of decrease of scalp activity can be appreciated in Figure 2a compared to Figure 3a. A scalp band was used in the first patient but not in the second because of multiple superficial scalp injuries, mainly on the right. One judges whether a good intravenous bolus injection was achieved by seeing good delineation of the carotid arteries in the neck. In cases of cerebral death one should see no intracranial arterial flow on the flow study images, and nonvisualization of the cerebral venous sinuses on the immediate static images.⁵ This is in comparison to the normal flow study which reveals bilateral extracranial carotid flow and intracranial cerebral blood flow (see Figure 1a), and static images showing activity in the sagittal and transverse cerebral sinuses (see Figure 1b). Ac-

quired data of the computer can be used to enhance minimal activity.

In summary, radionuclide cerebral angiography has been found to be efficacious in evaluating patients, in the appropriate clinical setting, for absence of cerebral circulation. The increasing availability of portable scintillation cameras is likely to make this a procedure of ever-increasing utility. The diagnosis of "cerebral/brain death" remains a clinical one which can receive objective supportive evidence from several examinations, of which a radionuclide cerebral angiogram is one. ★★★

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References

1. Nagle, C. E.: Use of immediate static scans in combination with radionuclide cerebral angiography as a confirmatory test in the diagnosis of brain death. *Cl. Nucl. Med.* 5:152-153, 1980.
2. Goodman, J. M. and Heck L. L.: Confirmation of brain death at bedside by isotope angiography. *JAMA* 238:966-968, 1977.
3. Black, P. M.: Brain death. *N. Engl. J. Med.* 299:338-344, 1978.
4. Collaborative study: An appraisal of the criteria of cerebral death. *JAMA* 237:982-986, 1977.
5. Mishkin, F.: Determination of cerebral death by radionuclide angiography. *Radiol.* 115:135-137, 1975.
6. Walker, A. E.: Advances in the determination of cerebral death. *Adv. Neurol.* 22:167-177, 1979.



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SIDNEY O. GRAVES, JR., M.D.
Natchez, Mississippi

At the 114th Annual Session, held this last May, then-President Dr. Faser Triplett, recommended that a committee be appointed to study MSMA's organizational structure. The House of Delegates adopted this recommendation. This committee is to study the present council and committee structure, the component society structure, the trustee districts of the association, and the format of the annual scientific program.

With the advice of the Board of Trustees, I have appointed the committee and all nominees have agreed to serve. They are Drs. Walter Rose, Indianola; Thomas Glasgow, Oxford; Steve Parvin, Starkville; Arthur Derrick, Durant; Stan Wade, Meridian; Faser Triplett, Jackson; C. P. Crenshaw, Collins; Van Craig, Natchez; and Paul Moore, Sr., Pascagoula, who will serve as chairman. The committee's first meeting will be held in early September. It is hoped that a report will be ready to present to the House of Delegates at the 115th Session.

This is going to be a tough job for the committee. It will require much research, deliberation and compromise to arrive at an acceptable report.

All four of the committee's agenda items are important. The most controversial subject has to be the trustee districts. The one man, one vote equality of representation between the districts has been debated for years, but no acceptable solution has been found. Now is the time to face this problem head-on.

The relationship between MSMA and the component societies has improved during recent years, but there is room for more improvement.

I don't believe anyone will argue that the present council and committee structure needs altering. The only question is how much.

The annual scientific session has become a multi-headed monster. A way must be found to decapitate without killing.

As I said before, this is a large order to place on nine busy physicians. I am sure that they would appreciate any advice from members of the association.

★★★

A Crucial Vote For Medicine's Future

When Congress returns from its Labor Day recess, one of the most crucial legislative issues facing medicine in this decade will come to a vote. That issue is whether the Federal Trade Commission will continue and expand its jurisdiction over the profession.

In the Senate a bill (S.B. 2499) has been reported by the Senate Commerce Committee which clarifies that the FTC has no jurisdiction over state-regulated professions. In the House, the Energy and Commerce Committee has reported a bill (H.R. 6995) which doesn't address the issue of FTC jurisdiction over the professions. There has been agreement, however, that there will be debate on the issue, and the Luken-Lee bill, which places a moratorium on FTC action regarding state-regulated professions, will be offered as an amendment to H.R. 6995.

Thanks to the efforts of many Mississippi physicians, our congressional delegation has indicated their support for the Luken-Lee bill and S.B. 2499. The AMA has been active on the national level gathering congressional support as evidenced by the fact that S.B. 2499 has been reported to the Senate with the clarification regarding FTC jurisdiction over the professions, and Luken-Lee has some 219 sponsors in the House.

The stage is set, the actors are ready, and sometime this month we should have an indication of just what role, if any, the FTC will play in the future of the medical profession. — C.L.M.

Medico-Legal Brief

MD Wins Suit Against Blue Shield

A physician was properly awarded \$112.50 from Blue Shield as part of his fee for a closed reduction of an arm fracture, the Missouri Supreme Court ruled.

The physician treated a patient for an arm fracture in August 1977. He charged a total of \$380.50, which included \$50.00 for ER consultation, \$68.00 for X-rays, and \$262.50 for a closed reduction of the fracture and four office visits. The patient was covered under a Blue Shield policy, which provided that Blue Shield would defend the patient if a non-participating physician charged more than Blue Shield felt was usual and customary. The physician was a non-participating physician, and Blue Shield established a fee of \$200 for the physician.

The physician then sued the patient and Blue Shield for \$112.50. A trial court found in favor of the physician for the amount requested, and the Supreme Court affirmed. Blue Shield contended that the physician had not proven the reasonable value of his fee by expert testimony. The Supreme Court said the physician had demonstrated that he did not arbitrarily establish his fees and that the amount billed was his standard charge for the service. The physician's own testimony was sufficient to support the verdict, the court said. — *Richard B. Curnow, M.D., Inc. v. Sloan*, 625 S.W.2d 605 (Mo.Sup.Ct., Dec. 8, 1981; rehearing denied, Dec. 8, 1981)

POSTGRADUATE CALENDAR

Sept. 24, 1982

STABILIZATION/RESUSCITATION OF THE NEWBORN
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Pediatrics Division of Newborn Medicine and the Medical Center Division of Continuing Health Professional Education.

Coordinator: Philip G. Rhodes, M.D., UMC associate professor of pediatrics and chief of the newborn division.

This program will cover normal and abnormal respiratory adaptation in the newborn. Topics include identification of clinical signs, methods of evaluation and management of respiratory distress in the newborn and current theories of immediate and long-term respiratory support in the perinatal period. Fee: \$35. Credit: 5 contact hours (.5 CEU) Category I, AMA; AAFP.

Oct. 29, 1982

FLUID BALANCE AND NUTRITION IN THE NEWBORN
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Pediatrics Division of Newborn Medicine and the Medical Center Division of Continuing Health Professional Education.

Coordinator: Philip G. Rhodes, M.D., UMC associate professor of pediatrics and newborn division chief.

This course will define normal electrolyte and nutritional needs of the high risk newborn. Parameters for evaluation of nutritional support and immediate and long-term evaluation management are included. Fee: \$35. Credit: 5 contact hours (.5 CEU) Category I, AMA; AAFP.

Nov. 2, 1982

MISSISSIPPI THORACIC SOCIETY MEETING AND BOSWELL LECTURE
University Medical Center, Jackson

Sponsored by the Mississippi Lung Association, the Mississippi Thoracic Society, the University of Mississippi School of Medicine Department of Medicine, Pulmonary Division, and the Medical Center Division of Continuing Health Professional Education.

Coordinator: Jerald Jackson, M.D., Hattiesburg

This program offers the primary care and specialty clinician a review of the pathophysiology, diagnosis and treatment of thromboembolic disease. The Boswell Lecture will present the latest concepts in thrombolytic therapy. Fee: \$10. Credit: 5.75 contact hours (.57 CEU) Category I, AMA.

FUTURE CALENDAR

Nov. 12, 1982

NUTRITION IN THE NEWBORN
University Medical Center, Jackson

For more information about these and other programs, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone (601) 987-4914.

Symposium on Venereal Diseases

The Mississippi State Department of Health will sponsor a symposium for physicians on sexually transmitted diseases November 4-5, at the Holiday Inn Medical Center in Jackson.

Dr. Paul Wiesner, director of the Venereal Disease Control Division, Centers for Disease Control, will serve on the faculty. Topics will include current concepts of sexually transmitted disease and current treatment recommendations. A presentation on herpes infection focusing on current concepts on its diagnosis and management is also on the agenda.

Details of the symposium will be distributed to physicians. Further information can be obtained from Dr. Ed Thompson at the State Department of Health, P.O. Box 1700, Jackson, MS 39205, telephone 354-6650.

Symposium on Gastrointestinal Ca

Aspects of the three major gastrointestinal cancers will be discussed at a symposium scheduled for September 23 at the Holiday Inn Downtown in Jackson. The conference begins at 8:00 a.m.

There will be no fee charged, according to the American Cancer Society, Mississippi Division, which is co-sponsoring the conference with the University of Mississippi Division of Continuing Education. The program is supported in part by a contribution from the Dameron Friley Spruill and Wilma Zay Spruill Lectures in Oncology Fund, University of Mississippi Alumni Association.

For more information, contact the American Cancer Society, 345 N. Mart Plaza, Jackson, MS 39206; telephone (601) 362-8874.

NEW MEMBERS

COLLIER, MICHAEL EDWARD, Greenwood. Born Lynn, MA, Dec. 1, 1951; M.D., University of Texas Southwestern Medical School, Dallas, 1977; interned Barnes Hospital, St. Louis, MO, one year; radiology residency, Parkland Hospital, Dallas, 1978-81; elected by Delta Medical Society.

DEES, STRAWFORD HALE, III, Biloxi. Born Corinth, MS, March 3, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned William Beaumont Army Medical Center, El Paso, TX, one year; surgery residency, same, 1973-77; plastic surgery residency, Walter Reed, Washington, DC, 1977-79; elected by Coast Counties Medical Society.

HOOKE, PHILLIP A., West Point. Born Tupelo, MS, June 6, 1943; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned Mayo Clinic, Rochester, MN, one year; allergy and dermatology residency, same, 1976-79; medical genetics residency, Harvard Medical School, Boston, 1979-81; elected by Prairie Medical Society.

MARSALIS, WILTON LOWELL, Meridian. Born Meridian, MS, May 20, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned Carraway Methodist Medical Center, Birmingham, AL, one year; anesthesiology residency, University of Alabama, Birmingham, 1980-82; elected by East Mississippi Medical Society.

ROSS, DIANE ELLEN, Biloxi. Born New York, NY, Jan. 1, 1949; M.D., Medical College of Pennsylvania, Philadelphia, 1969; interned Thomas Jefferson University Hospital, Philadelphia, one year; neurology residency, Mount Sinai Hospital, New York, 1974-75; elected by Coast Counties Medical Society.

SOUTH, DWALIA SHERREE, Ripley. Born Ripley, MS, April 23, 1955; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned in family medicine, University of Tennessee, Jackson, 1980-81; elected by North Mississippi Medical Society.

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PERSONALS

JAMES ACHORD of UMC attended a recent committee meeting of the American College of Gastroenterology in Atlanta.

WILLIAM BATES of UMC recently was visiting lecturer for the Wisconsin State Ob-Gyn Society in Sturgeon Bay, Wisconsin.

BLAIR BATSON of UMC was an examiner for the American Board of Pediatrics in Milwaukee, Wisconsin.

THOMAS H. CABELL and V. JOHN FORD, III have associated with Abernethy Eye Clinic, 653 North State Street, Jackson, for the practice of ophthalmology.

ROBERT L. CROCKER announces the opening of his office for the practice of family medicine at Reservoir Family Clinic, 101 Spillway Road, Brandon.

EDGAR M. DAPREMONT, JR. of Gulfport announces the opening of his clinic for the practice of ophthalmology at 419 Courthouse Road.

EDGAR DRAPER of UMC presented a paper to the Consultation Liaison Service in Chicago recently and also presented grand rounds at Washington University.

THOMAS D. ELMORE has associated with Physicians and Surgeons Clinic, South Boulevard Drive, in Amory, for the practice of obstetrics and gynecology.

CARL EVERS of UMC attended the recent national steering committee meeting of the Group on Student Affairs — Association of American Medical Colleges in Washington, DC.

STEVEN B. FINEBURG of Pascagoula announces the association of HARRIS G. BARRETT for the practice of family medicine.

J. M. FORD of Baldwin announces the association of H. T. PALMER for the practice of family medicine.

BLAIR FRANCIS FRASER has established his practice of family medicine in the Medical Arts Building, Coffeerville.

ALAN E. FREELAND of UMC spoke on "Infections of the Hand" and "Severe Extremity Injuries" during the National Conference on Rural Primary Care in Jackson.

DAVID J. GANDY has associated with Lakeland Orthopaedic Clinic, P.A., 878 Lakeland Drive in Jackson, for the practice of orthopaedic surgery and pediatric orthopedics.

RAYMOND F. GRENFELL of Jackson has been named a fellow of the American College of Physicians.

J. BROOKS GRIFFIN has associated with The Woman's Clinic, 918 North State Street in Jackson, for the practice of obstetrics and gynecology.

BARNEY J. GUYTON has associated with Internal Medicine Associates of Tupelo, Ltd., for the practice of gastroenterology.

JAMES E. HALL announces the opening of his office for the practice of ophthalmology at 1022 Biglane Drive in Brookhaven.

WILLIAM M. HEMETER has established his office for the practice of ophthalmology at 1018 W. Sixth Avenue in Picayune.

NOEL H. JOHNSON has associated with the Biloxi Ob-Gyn Clinic, P.A., 1121 W. Division Street, for the practice of obstetrics and gynecology.

ALLEN E. KARSTENS has associated with the Pediatric Clinic, 1101 South 28th Avenue, Hattiesburg, for the practice of pediatrics.

HERBERT LANGFORD of UMC attended a meeting in July of the Clinical Trials Review Committee of NIH in Minneapolis, Minnesota.

JOHN PAUL LEE of Forest announces the association of BILL LEWIS in the general practice of medicine at 285 East First Street.

BILLY W. LONG of Jackson has been named a fellow of the American College of Physicians.

RODNEY N. LOVITT has associated with The Hattiesburg Clinic, P.A., for the practice of family medicine at the Petal Family Medicine Clinic.

C. FOSTER LOWE AND SIDNEY O. ROSS, JR. of McComb announce the association of STEVEN C. WILLIAMS for the practice of general, thoracic and peripheral vascular surgery.

RAYMOND MARTIN, III has associated with Jackson Surgical Group, 514-A East Woodrow Wilson Drive, for the practice of general and vascular surgery.

JAMES E. McDONALD has associated with Radiological Group, 1151 North State Street in Jackson, for the practice of radiology.

CHARLES W. MONTGOMERY and SPENCER L. SCHREITER of Tupelo announce the association of JULIAN B. HILL for the practice of medical oncology at 806 Garfield Street.

THOMAS LANE MOORE, JR. of McComb received the Book of Golden Deeds Award presented by the McComb Exchange Club.

JOHN A. MURFEE of Columbus announces the association of JOSEPH S. BOGGESS for the practice of otolaryngology, plastic and reconstructive surgery of the head and neck, and allergy.

GARY H. NOWELL has established his practice of internal medicine in association with WILLARD H. BOGGAN, DWIGHT S. KEADY, and MARVIN H. JETER at 2969 University Drive, Suite 102, in Jackson.

CHARLES S. O'MARA has associated with Surgical Clinic, P.A., 1600 North State Street, in Jackson, for the practice of vascular surgery.

JAMES B. PENNEBAKER has associated with The Hattiesburg Clinic, P.A., for the practice of internal medicine and rheumatology.

PATRICK L. PIERCE of Gulfport was installed president-elect of the Louisiana/Mississippi Ophthalmological and Otolaryngological Society at the recent annual meeting in Biloxi.

SYBIL F. RAJU of Jackson was recently named a fellow of the American College of Physicians.

JOHN E. RAWSON and CHARLES A. FRIEDMAN of Jackson announce the association of DAVID F. WENDER for the practice of neonatology at the Newborn Group, 1850 Chadwick Drive.

DONALD L. ROBERTS has associated with the Eye, Ear, Nose & Throat Clinic, 4500 15th Street, Gulfport, for the practice of otolaryngology.

RANDOLPH J. ROSS has established his practice of adult and pediatric urology at the Hattiesburg Urology Clinic, P.A., 2802 Mamie Street.

RANDY H. RUSSELL announces the opening of this office for the practice of ophthalmology at Hinds Professional Building, 1815 Hospital Drive, Jackson.

L. VAUGHAN RUSH, JR. of Meridian was named to the Board of Governors of the American Fracture Association at the recent 43rd annual meeting in Cancun, Mexico.

HENRY J. SANDERS of McComb is chairman for Congressman Wayne Dowdy's re-election campaign. Dr. Sanders was chairman of Dowdy's successful campaigns for mayor of McComb and for Congress.

SOMPRASONG SONCHAROEN of Jackson presented an abstract on reconstruction of mandibular defects at the University of Maryland Surgical Society's biennial meeting.

FAYE SPRUILL of Jackson was instructor for a course on recovery of human skeletal remains sponsored by William Carey College and the Forensic Science Institute of the South.

KENNETH W. STUBBS has associated with ILEY F. DILLON of Natchez for the practice of internal medicine.

A. T. TATUM of Petal recently received the John B. Howell Memorial Award presented by the Mississippi Academy of Family Physicians.

VAN C. TEMPLE of Hattiesburg recently was honored with a reception during "Van Temple Day" commemorating his 50th year of medical practice.

ROBERT D. VOLLER has associated with Columbus Children's Clinic for the practice of pediatrics.

RALPH T. WICKER of Laurel announces the association of MICHAEL W. LOWRY for the practice of neurological surgery.

DAN WOODLIFF has associated with Internal Medicine Group of Jackson for the practice of internal medicine.

At some time each of us will probably visit the country doctor's office at the Agriculture Museum. To date it is not funded. I realize that we are besieged daily for contributions to some cause or other, but we alone are responsible for this particular project. If each physician would contribute only \$20, our funding problem would be over. Please help. You'll be glad you did when you see it. — W.M.D.

DEATHS

MOUNGER, SAMUEL G., Greenwood. Born Greenwood, MS, Aug. 5, 1910; M.D., Tulane University School of Medicine, New Orleans, 1933; interned Hotel Dieu, New Orleans, 1933-34; Vicksburg Charity, 1934-36, and New Orleans Charity Hospital, 1936-67; died April 30, 1982, age 71.

MEDICAL ORGANIZATION

Council Announces Preliminary Plans For MSMA's 115th Annual Session

The Council on Scientific Assembly met July 29 at MSMA headquarters to schedule events for the 115th Annual Session set for May 11-15, 1983, at the Royal D'Iberville Hotel in Biloxi. Since the upcoming annual session will inaugurate the new Wednesday through Sunday format mandated by the House of Delegates, the Council made a number of scheduling changes for the five-day meeting.

Under the new schedule the House of Delegates will conduct its meetings on Thursday morning, May 12, and Sunday morning, May 15. Reference committees will meet on Thursday afternoon.

Many of MSMA's 14 scientific sections, accustomed for years to meeting on certain days of the session, will meet at new times under the altered schedule. The scientific assembly will begin on Friday morning, May 13, with sessions of the sections on surgery, medicine and family practice. Other sections will meet on Friday afternoon (sections on ob-gyn, preventive medicine and pediatrics) and Saturday morning (sections on pathology, radiology, psychiatry, anesthesiology, dermatology and urology). Still unscheduled are the Section on EENT and the Section on Orthopedic Surgery.

The James Grant Thompson Memorial Lecture will be presented during the Section on Surgery. Dr. John Beal, the incoming president of the American College of Surgeons, will deliver the address. Rep-

resentatives of the sections are now completing arrangements for their scientific sessions, and the complete program will be outlined in future issues of JOURNAL MSMA.

The special events calendar includes all of the activities usually offered during the annual session, with an additional one on the schedule for this meeting. The Mississippi Medical Political Action Committee (MMPAC) will sponsor a reception on Saturday evening, May 14, during which MSMA members will have the opportunity to talk with candidates for state-wide offices, who will be special guests.

Mark Russell, noted political satirist, musician and columnist, will be the feature entertainment for the annual MSMA/MSMA Auxiliary banquet, set for Friday evening, May 13.

Wednesday evening, May 12 is the date for the MSMA President's Reception. The University of Mississippi Medical Alumni Association and other alumni organizations will conduct their annual fellowship events on Thursday evening, May 14.

Golf, tennis and fishing are on the agenda for the 115th annual session, as in past years. The golf tournament will be held Wednesday morning; the tennis tournament will be conducted Saturday morning; and the two-day fishing rodeo will be conducted Friday and Saturday.

Future issues of JOURNAL MSMA will outline more information about the upcoming meeting, including the complete program for the MSMA Auxiliary's 60th Annual Session.



Council on Scientific Assembly plans 115th Annual Session.

Board of Trustees Holds Summer Meeting

The Board of Trustees held its regular summer meeting August 4-6 in Natchez and joined the Homochitto Valley Medical Society in honoring MSMA president, Dr. Sidney O. Graves, who was given a special plaque in recognition of service on behalf of the medical profession.

The Board handled a full agenda of business to include reports referred from the House of Delegates and other association Councils and Committees.

Among items from the House of Delegates considered by the Board were the establishment of a patient inquiry program and the appointment of a committee to study MSMA reorganization and the format of the annual scientific program.

Reports on activities of the Council on Scientific Assembly, the association's new committee on DWI, and the Mississippi Medical Political Action Committee were also received by the Board.

MSMA's delegates to the AMA reported on actions by that organization's House of Delegates at its recent annual session and particularly noted the adoption of a MSMA resolution dealing with foreign medical graduates.

The Board also received a preliminary report on planning of an MSMA group health insurance program and authorized the Executive Committee of the Board to proceed with further organization of this project.

A special MSMA and Auxiliary seminar was scheduled for March 5-6, 1983 in Jackson. The seminar will feature speakers on "Critical Issues in Health Care" and will include a political action workshop conducted by the American Medical Political Action Committee.



Dr. Ellis Moffitt, chairman of the MSMA Board of Trustees, addresses guests at a dinner honoring Dr. Sidney O. Graves, MSMA president, at right.



Dr. James E. Funderburg, president of the Homochitto Valley Medical Society, presents Dr. Graves with a plaque in recognition of his service to MSMA.

The Board also heard plans for a legislative program by MSMA to seek changes in certain laws dealing with professional liability of physicians.

The Board directed new efforts to solicit funds to build a Country Doctor's Office at the Agricultural and Forestry Museum in Jackson and to support MSMA's Disabled Physician's Program.

Attending the meeting of the Board of Trustees were: Sidney O. Graves, Jr., M.D., Natchez, president; Whitman B. Johnson, Jr., M.D., Clarksdale, president-elect; R. Faser Triplett, M.D., Jackson, immediate past president; J. Elmer Nix, M.D., Jackson, secretary-treasurer; Carl G. Evers, M.D., Jackson, speaker of the House of Delegates; James C. Waites, M.D., vice speaker of the House of Delegates; James O. Gilmore, M.D., Oxford, delegate to AMA; W. Lamar Weems, M.D., Jackson, delegate to AMA; and the following trustees: Ellis M. Moffitt, M.D., Jackson, chairman; W. Boyce White, M.D., Laurel, vice chairman; Roy D. Duncan, M.D., Pascagoula, secretary; Virginia S. Tolbert, M.D., Ruleville; W. Joseph Burnett, M.D., Oxford; William C. Gates, M.D., Columbus; William B. Hunt, M.D., Grenada; James O. Manning, M.D., Jackson; George L. Arrington, M.D., Meridian; and David R. Steckler, M.D., Natchez.

MSMA Establishes Patient Inquiry Program

Under the direction of the Board of Trustees and with the approval of the House of Delegates, MSMA will introduce a patient inquiry program throughout the state over the next several months.

The program, which will be staffed at MSMA's office in Jackson, will respond to patients' inquiries about physicians' services in Mississippi. Publicity about the program will be distributed to the news media and through MSMA members' offices.

The Board of Trustees views the new program as an effort to strengthen MSMA's long-time grievance committee procedures for resolving patients' inquiries about medical services provided by MSMA members.

The new patient inquiry program will seek more visibility with both the public and MSMA members with the stated goals of improving physician/patient relationships and the professions' communication with the public. The latter goal was identified in a survey of MSMA members as one of the profession's most pressing needs in Mississippi.

The program will publicize a toll-free and local number at MSMA's office in Jackson which patients can call to inquire about medical services provided by MSMA members. Where component societies have active grievance committees, the program will be coordinated with them.

The association's Committee on Peer Review will oversee operation of the program under policies established by the Board of Trustees. The committee is charged with the responsibility of resolving complaints about medical services furnished by members of the association. The committee has no disciplinary authority but can file charges against a member before the association's Judicial Council which has jurisdiction over all matters involving the "Principles of Medical Ethics."

Complete information about the program and materials for patients will be furnished to each MSMA member as the program is implemented in his or her area, and MSMA component societies will be urged to take an active part in implementing the program in their respective areas.

JOURNAL MSMA encourages your participation. Comments, inquiries and suggestions are invited.

1983 MSMA-Robins Award Nominations Announced

The 22nd annual Mississippi State Medical Association-Robins Award for outstanding community service by a state physician has been announced to the component medical societies by the Board of Trustees. The 1983 award will be presented at the 115th Annual Session.

Each component society has been invited to submit a nomination for the honor. Deadline for nominating letters is January 3, 1983. The Board of Judges, consisting of the MSMA vice presidents, will review the nominations.

The award is sponsored annually by the association and the A. H. Robins Company of Richmond, VA. The series was instituted in 1962, and the award consists of a sculptured bronze plaque in bas-relief, engraved, and mounted on a mahogany panel.

The 21 Mississippi physicians who have received the high honor are: Dr. Thomas G. Ross of Jackson; Dr. Frank M. Davis of Corinth; Dr. Howard A. Nelson of Greenwood; Dr. Maura J. Mitchell of Ellisville; Dr. J. T. Davis of Corinth; Dr. Frank M. Acree of Greenville;

Dr. W. H. Anderson of Booneville; Dr. Omar Simmons of Newton; Dr. W. J. Aycock of Calhoun City; Dr. Walter H. Rose of Indianola; Dr. Reginald P. White of Meridian; Dr. W. A. Long, Jr., of Jackson; Dr. Virginia S. Tolbert of Ruleville; Dr. Thomas M. Davis of Jackson;

Dr. Thomas G. Barnes of Greenville; Dr. Hugh Banks Barnes of Hattiesburg; Dr. Verner S. Holmes of McComb; Dr. W. L. Jaquith of Whitfield; Dr. Jack Atkinson of Brookhaven; Dr. W. Lamar Weems of Jackson; and Dr. John G. Caden of Jackson.

SBH Details 1983 Block Grant Expenditures

The Mississippi State Board of Health took a philosophical but practical approach to its plan for spending federal fiscal year 1983 block grant funds. The state health department administers the Maternal and Child Health and the Preventive Health and Health Services Block Grants.

"The overall guiding principle for use of public resources in the health field should be to provide the greatest benefit in improving the health status of the individual and of the community as a whole," said State Health Officer Alton B. Cobb. "This, coupled with the basic public health principle that prevention

is both better and less costly than cure, forms the basis for decisions regarding allocation of block grant funds for health.

"The complexities of applying cost/benefit principles to human service programs make it impractical to formulate a set of precisely drawn standards which can be used to prepare a final listing of proposed programs and services which will assure that, in every instance, dollars spent will purchase the maximum amount of improvement in the public's health status," Dr Cobb said. "Still, by applying fundamental public health principles, we can approach this goal and assure, so far as possible, the best outcome for the dollars spent."

In developing priorities for expenditure of Preventive Health and Health Services Block Grant funds, Department of Health staff aimed at the goal the name implies: prevention. Highest priority goes to programs and services which directly provide primary prevention of disease — such programs as immunization.

Programs and services which provide secondary prevention of disease, such as hypertension, rank next in order of priority. Some programs — sexually transmitted disease control, for example — have both secondary and primary elements and are prioritized accordingly.

Next in rank are programs aimed at protection of the public's health through standards and regulation. These include, for example, jail and milk sanitation.

Emergency medical services and health education/risk reduction are programs directed at planning and systems development; these and other similar programs rank fourth in priority.

The State Department of Health expects to have approximately \$2.8 million for preventive health programs, projects, and support in FY 1983; this includes block grant money, categorical funding for immunization and sexually transmitted diseases (STD), and some 1982 carry-over funds.

On the recommendation of agency staff, the Board of Health has agreed to budget the following for expenditure of the near \$2.8 million in FY 1983: immunizations, \$729,210; hypertension, \$692,500; STD, \$596,626; emergency medical services, \$388,235; sanitation — penal institution and milk, \$155,781; grant administrative reserve, \$115,000; public health dentistry — fluoridation, \$98,218; and rape prevention and crisis intervention, \$32,871.

Programs and services with a strong preventive element also get high priority within each category in the Maternal and Child Health Block Grant funding area. The key is provision of services in as effective and efficient manner as possible.

Programs and services which provide basic MCH services to the widest possible number of people are given first priority. Examples of such programs are basic maternity care and infant/child care.

An estimated 21,500 women, 21,465 infants, and 410,062 children need services provided under the MCH Block Grant. These women and children live at or below 125% of the non-farm poverty level as defined by the U.S. Office of Management and Budget.

Programs and services which provide an essential service not otherwise available to a certain group of people rank second. Examples include high-risk maternity care, the Newborn Intensive Care Unit at the University of Mississippi Medical Center and Newborn Transport system, and the Children's Medical Program (formerly Crippled Children's Service).

In third priority are programs that provide important but not essential services to wide or restricted ranges of people. Included are educational, social, nutrition, and other important services that support and enhance patient care.

Amounts budgeted for MCH programs and projects during FY 1983 are as follows: maternity services and child health, \$4,128,949; children's medical, \$1,575,621; adolescent pregnancy, \$67,500; and Holmes County Maternal and Infant Care, \$37,500.

Some \$700,000 transfer from the Low Income Energy Assistance Program is allocated to contractual services to assure access to delivery services for approximately 500 women in community hospitals, tertiary care for high risk mothers and babies at the University Medical Center, and voluntary tubal ligation services for 266 high risk women to prevent future pregnancies.

"We believe that health and social service funding should provide programs for those unable to provide for themselves; we must provide these services in the most humane and cost-effective ways known," Dr. Cobb said.

"The Department of Health's plan for spending block grant funds supports the federal government's underlying principle of the block grant concept: that resources can be more appropriately allocated by the states, based on each individual state's determination of problems, needs, and priorities within that state," commented Dr. Cobb. "Still, looking at the national plan, we do have serious reservations on the proposals for program swaps and transfers. We are afraid that the states with the greatest needs for human services will be unable to support adequate services for the poor."

Hypertensives Are Target Of VA Research Project

A special research project now under way at the Veterans Administration Medical Center in Jackson is designed to determine the effects of exercise training on blood pressure and cardiovascular risk in mild hypertensives.

The targeted population includes males between the ages of 18 and 55 with diastolic blood pressure between 90 and 104 mm Hg, with no other significant disease and who are not currently on antihypertensive medication. Those on diuretics alone may qualify for participation, but they must first have their diuretic withdrawn under medical supervision and their blood pressure must remain below 105 mm Hg, diastolic.

According to Dr. John Martin, the principal investigator and a clinical psychologist at the VA and the University of Mississippi Medical Centers, approximately 10 studies have looked at effects of exercise in hypertension with a majority of them showing clinically important reductions in blood pressure. Unfortunately, none of the studies employed a control group of hypertensives. In contrast, the current project will employ a second hypertension group which will control for the possible confounding effects of repeated measurements (regression to the mean of blood pressure), therapist contact and expectation. According to Dr. Martin, in light of the findings from the Hypertension Detection and Follow-up Program, it would be unethical and potentially dangerous to withhold effective chemotherapy from any of the hypertensive subjects for an extended period of time. Hence, training will occur only for three months, after which time all those whose mild hypertension is not controlled (<90 mm Hg., diastolic) will be referred for drug therapy. In the event that one form of exercises is found highly effective, then this will be offered, possibly as an adjunct to chemotherapy, to all control subjects at three-months. As an additional safeguard, hypertensives who experience any sustained elevation (above 104 mm Hg.) in diastolic blood pressure any time during the project will be immediately dropped from the study (and considered a treatment "failure") and referred for drug therapy.

Since weight and sodium/potassium changes might confound results, these variables will be closely monitored throughout the project. In addition, changes in overall cardiovascular risk profiles will be tracked, including triglycerides, total and HDL cholesterol measurement, and graded exercise/fitness testing. Because pilot data suggests that

many, but not all, mild hypertensives are benefited by exercise, renin, catecholamine and sodium pump function measures will be taken in an attempt to identify what types of hypertensives are likely to benefit the most, and the least, from the exercise regimen.

Openings are still available for individuals interested in participating in this project. All participants will receive a free fitness assessment and cardiovascular risk analysis. They will receive a small payment for engaging in a supervised exercise program at the VA Medical Center. Any interested hypertensives or referring physicians should call the VA at 362-4471 ext. 1126 (The Heart Health Program) for further information or to schedule a screening appointment. In addition to Dr. Martin, the principal investigator of this \$228,000 three-year project, Dr. Patricia M. Dubbert, assistant professor of psychiatry (psychology), serves on the staff as project director. Libbie Lake and Tony Burkett are research technicians. Co-investigators of the grant are Dr. William C. Cushman, assistant professor of medicine, and Dr. L. H. Tjeng, chief of rehabilitation medicine (VA). Dr. Herbert Langford, professor of medicine, UMC, and Dr. Richard G. Hutchinson, associate professor of medicine, are the medical consultants.


NOTICE

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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

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Dosage: Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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RECOLLECTIONS

Medical perspectives on the then-emerging world of space exploration were discussed twenty years ago in JOURNAL MSMA.

Published in the September 1962 issue were papers from MSMA's Symposium on Space Medicine, held during the 94th Annual Session. Introduced by Dr. Lawrence W. Long's keynote address, "The Fourth Environment," the special section of symposium papers included: "How Bioastronautics Looks at the Moon," by Dr. Hubertus Strughold; "Medical Problems of Space Flight," by Col. John Stapp; and "Use of Personalized Radio Telemetry Techniques for Physiological Monitoring in Aerospace Flight," by Lt. Col. David G. Simons, all of Brooks Air Force Base; and "Space: A Shield for Peace," by U. S. Senator John C. Stennis.


In the same issue, Dr. C. G. Sutherland, chairman of the Council on Scientific Assembly, announced the preliminary program for MSMA's 95th Annual Session, to be held at the Buena Vista Hotel in Biloxi. The program for the four-day meeting included sessions by MSMA's seven scientific sections.

Among other items making news in 1962 was the appointment of a six-man committee representing MSMA and the Mississippi State Bar to discuss the development of an interprofessional code.

It was announced that Dr. Victor E. Landry of Lucedale had been appointed to the Board of Trustees of State Mental Institutions by Governor Ross R. Barnett.

AMA dues for 1963 were to be increased to \$45, according to a news story which reported the second part of a two-year increase authorized by the AMA House of Delegates.





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Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

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For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonia.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides, patients with documented megaloblastic anemia due to folate deficiency, pregnancy at term, nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus, infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folate acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

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1. Rubin RH, Swartz MN: *N Engl J Med* 303 426-432, Aug 21, 1980. 2. Data on file, Medical Department, Hoffmann-La Roche Inc.

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IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, in rare instances, cardiac failure has developed during propranolol therapy. At the first sign of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and observed closely. a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol should be immediately withdrawn, b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Give special consideration to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Propranolol should be withdrawn slowly, since abrupt withdrawal may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta-blockade impairs the ability of the heart to respond to reflex stimuli. Except in pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery. In case of emergency surgery, the effects of propranolol can be reversed by administration of beta-receptor agonists such as isoproterenol or levaterenol, but such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), administer with caution, since propranolol may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta-receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA Propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia, especially in patients with labile diabetes. A precipitous elevation of blood pressure may accompany hypoglycemic attacks.

USE IN PREGNANCY Safe use in human pregnancy not established. Embryotoxic effects have been seen in animals at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if propranolol is administered, since it may occasionally produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

Observe laboratory parameters at regular intervals. Use with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura. **Central Nervous System** lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium and decreased performance on neuropsychometrics. **Gastrointestinal** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. **Allergic** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. **Respiratory** bronchospasm. **Hematologic** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. **Miscellaneous** reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta-blocker (practolol) have not been conclusively associated with propranolol. **Clinical Laboratory Test Findings** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

HOW SUPPLIED

TABLETS

Each hexagonal-shaped, orange scored tablet is embossed with an "I" and imprinted with "INDERAL 10" contains 10 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0421-81) and 1,000 (NDC 0046-0421-91). Also in unit dose package of 100 (NDC 0046-0421-99).

— Each hexagonal-shaped, blue, scored tablet is embossed with an "I" and imprinted with "INDERAL 20," contains 20 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0422-81) and 1,000 (NDC 0046-0422-91). Also in unit dose package of 100 (NDC 0046-0422-99).

— Each hexagonal-shaped, green, scored tablet is embossed with an "I" and imprinted with "INDERAL 40," contains 40 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0424-81) and 1,000 (NDC 0046-0424-91). Also in unit dose package of 100 (NDC 0046-0424-99).

— Each hexagonal-shaped, yellow, scored tablet is embossed with an "I" and imprinted with "INDERAL 80," contains 80 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0428-81) and 1,000 (NDC 0046-0428-91). Also in unit dose package of 100 (NDC 0046-0428-99).

The appearance of these tablets is a trademark of Ayerst Laboratories.
Store at room temperature (approximately 25° C)

INJECTABLE

— Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10 (NDC 0046-3265-10).
Store at room temperature (approximately 25° C)

7997/882

Reference: 1. Freis, E. D. Hypertension (Suppl. II) 3: 230 (Nov-Dec) 1981

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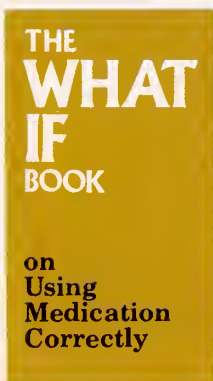
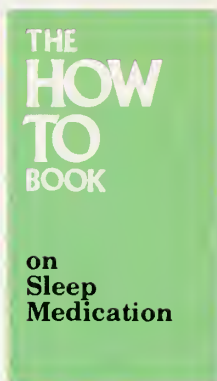
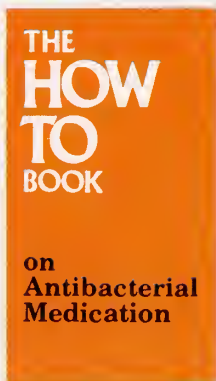
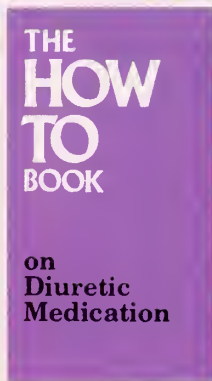
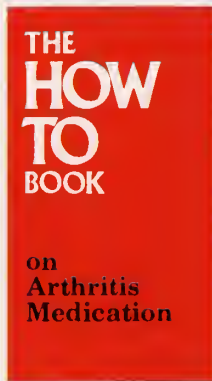
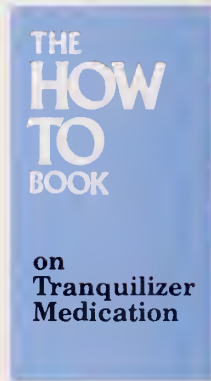
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She's back. How can you help her this time?

Many patients presented with physical symptoms are suffering from psychiatric illness, but are unaware of it. And while not all who suffer from mental illness or emotional problems need hospital treatment, hospitalization may be essential to provide a therapeutic environment in which the patient can effectively deal with his or her problems.

Riverside Hospital is a 56-bed, short-term care facility which provides intensive treatment of patients suffering from psychiatric illnesses, alcoholism, and drug dependencies. In Riverside's open, non-institutional environment, traditional and new, progressive psychotherapies are utilized.

Above all, care at Riverside is aimed at treating the patient with respect and dignity, fostering self-esteem, and returning the patient to independence and a satisfying, productive and happy life.

Riverside is licensed by the Mississippi Commission on Hospital Care, and is fully accredited by the Joint Commission on Accreditation of Hospitals.

The medical staff includes a large number of psychiatrists in private practice in the Jackson area. A toll-free number, 1-800-962-2180, has been established at the hospital for referral service to physicians on the active medical staff.

Physicians who have patients who would benefit from the type of treatment approach offered by Riverside may obtain referral information by contacting the Director of Admissions.

 **Riverside Hospital**

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NEWSLETTER

October 1982

Dear Doctor:

Over half of all surgical procedures are currently performed on an ambulatory basis. This includes nearly all surgical procedures performed by physicians in emergency medicine and three-quarters of those performed by general and family practitioners, according to a survey conducted by the American Medical Association's Socioeconomic Monitoring System.

Surgeons performed 40% of all ambulatory surgery. The survey found widespread interest by physicians in other specialty areas as well. The vast majority of ambulatory surgery is done in hospital-based ambulatory surgery centers and physicians' offices. Free-standing surgery centers are still not commonly used.

"Cost per case" or "diagnostic related group reimbursement" will apparently become the next hospital cost containment system aimed at getting a handle on the nation's increasing hospital bill. The new payment system is part of the 1982 Medicare amendments which the American Hospital Association called "the most far reaching changes in hospital payment policies since the beginning of the program in 1965." Under the system a hospital is paid according to an average cost per case or disease entity. Those hospitals at or below the average cost retain a percentage of the savings.

Physicians are donating services in most high-unemployment areas, according to an AMA survey of medical societies in the 20 hardest-hit areas. A Detroit medical society began recruiting physicians in June 1981 to make health care available to recently unemployed people who cannot afford medical services, and physicians from neighboring counties have now joined the program.

In Washington and Oregon, also, physicians are stepping in to provide free or reduced-cost medical care for the newly needy. Several societies have designed formal programs and in other societies, physicians are seeing non-paying patients on an individual basis.

The AMA survey revealed that "physicians have always treated patients who are unable to pay, and they will continue to do so." A Washington State Medical Association spokesman declared, "Most physicians are making every effort to help. No one is being turned away simply because he or she cannot pay."

Sincerely,



Patsy Silver
Managing Editor

When your overweight patients seek your help with a weight reduction plan...



The benefits will outweigh the risks when you prescribe MELFIAT® 105

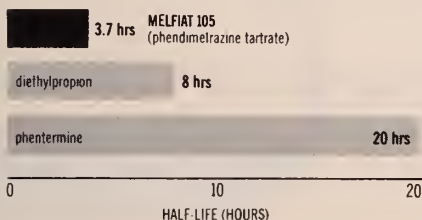
Because MELFIAT 105 effectively controls appetite.

MELFIAT 105 (phendimetrazine tartrate), an effective anorexiant, provides the appetite control overweight patients often need to begin a successful program of weight reduction. And the positive results of initial short-term therapy with MELFIAT 105 can help motivate them to a lifelong commitment of weight control.

Because MELFIAT 105 has a 3.7 hour half-life and low abuse potential.

Therapeutic efficacy combined with a short half-life and minimal abuse potential make MELFIAT 105 the drug of choice in the treatment of exogenous obesity. Because MELFIAT 105 has a short half-life, it minimizes drug accumulation and helps to eliminate such effects as disturbed sleep patterns. And, because MELFIAT 105 has significantly lower abuse potential than the amphetamines; there's less risk to your patients. According to a NIDA (National Institute on Drug Abuse) report, phendimetrazine appears to be the least abused anorexiant when compared to phentermine and diethylpropion.¹

Half-life comparison of MELFIAT 105 and other anorexiant²



Because MELFIAT 105 is in a sustained-release capsule.

MELFIAT 105 provides your patients with continuous drug delivery for appetite control that lasts throughout the day and helps to eliminate compulsive snacking and overeating at meals. In addition, the sustained-release capsule form maintains more constant blood levels of MELFIAT 105...without peaks and valleys.

Because MELFIAT 105 offers convenient, once-a-day dosage.

MELFIAT 105 is available in a convenient capsule containing 105 mg. The simple morning dosage regimen is designed to encourage compliance, minimizing the chance of missed doses and assuring optimum therapeutic results.

Because MELFIAT 105 is from Reid-Provident Laboratories, Inc. Reid-Provident has the highest standards of quality to assure that only the finest products reach you. An advisory board of research scientists, physicians, pharmacists, and other technical staff continually review existing products and new product proposals to make sure that the latest pharmaceutical technology is used in their design and manufacture. That's because Reid-Provident is committed to you and your patients.

For more information please write to Reid-Provident Laboratories, Inc. 640 Tenth Street, N.W. Atlanta, Georgia 30318

References: 1. Sheu YS, Ferguson JA, Cooper JR: *Evaluation of the Abuse Liability of Diethylpropion, Phendimetrazine, and Phentermine*, unclassified document ADAMHA, HHS, Office of Medical and Professional Affairs, NIDA, 1980. 2. Douglas JG, Munro JF: The role of drugs in the treatment of obesity, *Drugs* 21:362-373, 1981.

MELFIAT® 105 UNICELLES® ©

(phendimetrazine tartrate) 105 mg Sustained-Release Capsules

INDICATIONS AND USAGE: MELFIAT® 105 (phendimetrazine tartrate) is indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class (See CLINICAL PHARMACOLOGY) should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result).

WARNINGS: Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should be discontinued. Phendimetrazine tartrate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

Drug Dependence: Phendimetrazine tartrate is related chemically and pharmacologically to the amphetamines. Amphetamines and related stimulant drugs have been extensively abused, and the possibility of abuse of phendimetrazine tartrate should be kept in mind when evaluating the desirability of including a drug as part of a weight-reduction program. Abuse of amphetamines and related drugs may be associated with intense psychological dependence and severe social dysfunction. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high-dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG, manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia.

USAGE IN PREGNANCY: The safety of phendimetrazine tartrate in pregnancy and lactation has not been established. Therefore, phendimetrazine tartrate should not be taken by women who are or may become pregnant.

USAGE IN CHILDREN: Phendimetrazine tartrate is not recommended for use in children under 12 years of age.

PRECAUTION: Caution is to be exercised in prescribing phendimetrazine tartrate for patients with even mild hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of phendimetrazine tartrate and the concomitant dietary regimen. Phendimetrazine tartrate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdose.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure.

Central Nervous System: Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache, rarely psychotic episodes at recommended doses.

Gastrointestinal: Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances.

Allergic: Urticaria.

Endocrine: Impotence, changes in libido.

OVERDOSAGE: Manifestations of acute overdose with phendimetrazine tartrate include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states.

Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma. Management of acute phendimetrazine tartrate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Acidification of the urine increases phendimetrazine tartrate excretion. Intravenous phenolamine (Regitine) has been suggested for possible acute, severe hypertension, if this complicates phendimetrazine tartrate overdose.

DOSAGE AND ADMINISTRATION: Since MELFIAT® 105 (phendimetrazine tartrate) 105 mg is a sustained-release dosage form, limit to one sustained-release capsule in the morning. MELFIAT® 105 (phendimetrazine tartrate) is not recommended for use in children under 12 years of age.

HOW SUPPLIED: Each orange and clear sustained-release capsule contains 105 mg phendimetrazine tartrate in bottles of 100.

CAUTION: Federal law prohibits dispensing without prescription.

MELFIAT® 105 UNICELLES® III

(phendimetrazine tartrate)
Sustained-Release Capsules 105 mg



Cost is a primary concern of the Doctor in a cost conscious economy. A good malpractice insurance program must provide the services to satisfy budgetary responsibilities of the practice.

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DATELINE

Rabies Exposures In State

Jackson, MS - The Mississippi State Department of Health is intensifying its campaign to educate children and adults on the hazards of handling or playing with bats and other wild animals. Six Mississippians recently underwent prophylactic treatment after encountering rabid bats. In one case a man was bitten twice after kicking a bush and frightening a rabid bat. In another incident five children killed and dissected a bat which was later confirmed as rabid.

Phenylpropanolamine Reappraisal Urged

Chicago, IL - Three physicians writing in the Sept. 10 issue of JAMA have called for a reappraisal of phenylpropanolamine, found in more than 70 over-the-counter diet pills and nasal decongestants. They report two cases of acute kidney failure and muscle injury in patients who had taken diet pills containing the drug. They report other cases in the literature and speculate that the drug has a direct toxic effect on kidney and muscle cells.

Model Legislation Approved by Council

Chicago, IL - Model legislation reflecting the AMA position on look-alike drugs and the administration of epinephrine by lay people during emergencies was approved by the Council of State Governments for inclusion in its 1983 Suggested State Legislation. More than half of the states have adopted look-alike drug bills that prohibit the manufacture, distribution, and sale of non-controlled drugs that imitate the appearance of controlled substances.

MSMA Represented At Utilization Forum

Jackson, MS - MSMA Board of Trustees chairman Dr. Ellis M. Moffitt and AMA delegate Dr. W. Lamar Weems, both of Jackson, attended the National Conference on the Utilization of Health Services. The Chicago conference was cosponsored by the AMA, the American Hospital Association and Blue Cross and Blue Shield as a forum to exchange data, policy information, and various viewpoints on health care effectiveness. Secretary of HHS Richard Schweiker was keynote speaker.

AMACO Continues To Grow

Chicago, IL - The AMA's wholly owned medical liability insurance company, AMACO, continued to expand during the first six months of 1982. Premium volume continues to grow, according to a recent report. Written premiums during the first half of 1982 were approximately 60% higher than during the same period a year ago. AMACO now serves as a supporting reinsurer for 16 physician owned/medical society created liability insurance companies.

An added complication... in the treatment of bacterial bronchitis*



Brief Summary.

Consult the package literature for prescribing information.

Indications and Usage: Cefclor® (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coomb testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in fetuses receiving three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Cefclor.

Hypersensitivity reactions have been reported in about 1.5

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

Cefclor®

cefclor

Pulvules®, 250 and 500 mg

percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefclor® (cefclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). (100261R)

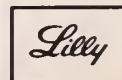
*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8:91, 1975.
2. Antimicrob. Agents Chemother., 11:470, 1977.
3. Antimicrob. Agents Chemother., 13:584, 1978.
4. Antimicrob. Agents Chemother., 12:490, 1977.
5. Current Chemotherapy edited by W. Siegenthaler and R. Luthy, II 880. Washington, D.C. American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 13:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.



Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

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DESCRIPTION VERMOX (mebendazole) is methyl 5-benzoylbenzimidazole-2-carbamate.

ACTIONS VERMOX exerts its anthelmintic effect by blocking glucose uptake by the susceptible helminths, thereby depleting the energy level until it becomes inadequate for survival. In man, approximately 2% of administered mebendazole is excreted in urine as unchanged drug or a primary metabolite. Following administration of 100 mg of mebendazole twice daily for three consecutive days, plasma levels of mebendazole and its primary metabolite, the 2-amine, never exceeded 0.03 µg/ml and 0.09 µg/ml, respectively.

INDICATIONS VERMOX is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (common roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections. Efficacy varies as a function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Whipworm	Common Roundworm	Hookworm	Pinworm
cure rates				
mean	68%	98%	96%	95%
(range)	(61-75%)	(91-100%)	—	(90-100%)
egg reduction				
mean	93%	99.7%	99.9%	—
(range)	(70-99%)	(99.5%-100%)	—	—

CONTRAINDICATIONS VERMOX is contraindicated in pregnant women (see Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

PRECAUTIONS PREGNANCY: VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

ADVERSE REACTIONS Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

DOSAGE AND ADMINISTRATION The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time. For the control of common roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days. If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

HOW SUPPLIED VERMOX is available as chewable tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets.

VERMOX (mebendazole) is an original product of Janssen Pharmaceutica, Belgium.

US Patent 3,657,267
December 1979

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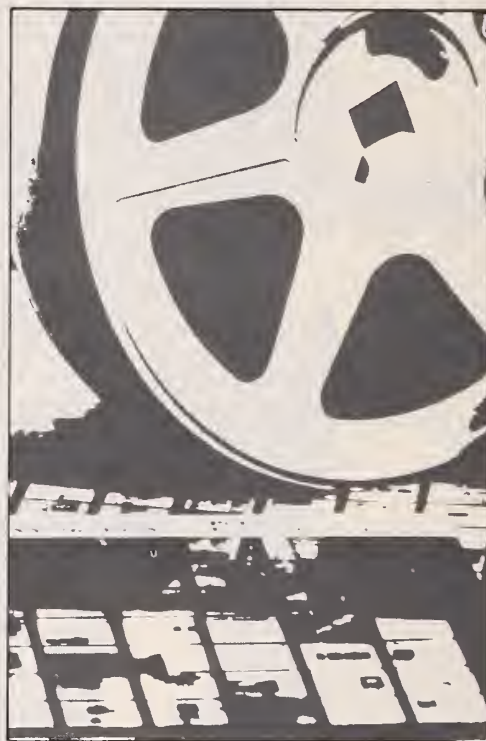
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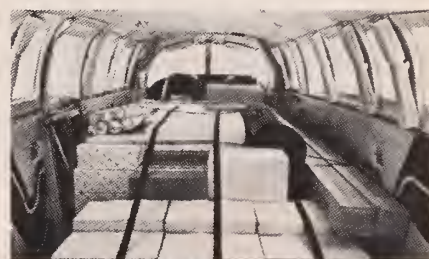
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sleep longer and seldom awaken
with morning hangover.

Feeling well rested in the morning usually means having slept well the night before. And for insomniac patients receiving hypnotic therapy, a good morning also means awakening with few side effects from their medication. Many physicians choose Dalmane for their patients who suffer from insomnia for this very reason.

Aside from enabling patients to fall asleep more quickly and sleep longer, Dalmane seldom causes morning hangover. Most Dalmane patients feel alert and refreshed when they awaken. In 53 paired-night clinical studies comparing Dalmane and placebo in 2010 insomniac patients with a variety of secondary diagnoses, most Dalmane patients awakened more alert and refreshed, and less groggy and drowsy, than on nights when they had taken only placebo.¹ In a double-blind crossover study of

42 patients in private practice, approximately three times as many patients reported feeling refreshed and alert upon awakening after a night on Dalmane (flurazepam/Roche) compared to placebo nights.² This difference was highly significant ($p < 0.001$). And a retrospective study of 2542 hospitalized patients who received Dalmane revealed only a 3.1% incidence of side effects.³

While residual effects from Dalmane therapy are infrequent, patients should be cautioned about drinking alcohol, driving or operating hazardous machinery after ingesting the drug.

Efficacy and safety in a broad range of patient types.

Over 2000 clinical trials involving more than 10,000 patients have shown that Dalmane patients fall asleep sooner, sleep longer and experience fewer nocturnal awakenings.⁴ The safety and efficacy of Dalmane have been demonstrated in medical and surgical hospitalized patients, in patients seen in office practice and in elderly patients.⁵⁻⁸ Since the risk of oversedation, dizziness, confu-



sion and/or ataxia increases with larger doses in the elderly, it is recommended that the dosage be limited to 15 mg.

Moreover, the efficacy and safety of Dalmane for the treatment of insomnia have been demonstrated in thousands of patients with a variety of primary medical conditions, including cardiovascular, neuropsychiatric, endocrine-metabolic, gastrointestinal, genitourinary, respiratory and musculoskeletal disorders.¹ Dalmane (flurazepam HCl/Roche) is contraindicated in pregnancy and in patients hypersensitive to the drug.

Avoids rebound insomnia upon discontinuation.

Rebound insomnia—a worsening of sleep beyond pretherapy levels after drug discontinuation—has been reported as a potential clinical problem with some hypnotics.^{9,10} However, this problem has not been reported with Dalmane. In eight out of eight sleep laboratory studies, there were no reports of rebound insomnia.¹¹ When you prescribe Dalmane, you can be confident of efficacy that enhances therapeutic progress. Your insomniac patients can be assured of a restful night, night after night—a good start for a good morning.

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 3. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977. 4. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 5. Meyer JA, Kurland KZ: *Milit Med* 138:471-474, Aug 1973. 6. Feller HL, Gibbons B: *Med Times* 101(8):130-135, Aug 1973. 7. Jacobson A *et al*: *Psychophysiology* 7:345, Sep 1970. 8. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 9. Kales A, Scharf MB, Kales JD: *Science* 201:1039-1041, Sep 1978. 10. Kales A *et al*: *JAMA* 241:1692-1695, Apr 1979. 11. Monti JM: *Methods Find Exp Clin Pharmacol* 3(5):303-326, 1981.

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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect.

Adults: 30 mg usual dosage; 15 mg may suffice in some patients. **Elderly or debilitated patients:** 15 mg recommended initially until response is determined.

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ORIGINAL PAPERS

Radiological Seminar CCXXV: A Bony Metastatic Lesion Mimicking the Appearance of a "Pelvic Ear"

KELLY SEID, M.D.,
DOROTHY LIN, M.D. and
BHARTI PATEL, M.D.
Jackson, Mississippi

A 64-YEAR-OLD MAN with prostate carcinoma had a history of bony metastasis by bone scan at an outside hospital and he was subsequently put on estrogen therapy. Twenty months later he was admitted to our hospital for cardiac problems and a bone scan was repeated. Whole body image obtained two hours after intravenous administration of 20 mCi of Tc-99m-MDP was within normal limits except for an area of slight increased focal activity in the region of the left anterior superior iliac spine shown on this anterior image of the pelvis (see Figure 1).

A radiograph of the pelvis (see Figure 2) showed asymmetry of the anterior superior iliac spines with the left side having the configuration of a normal developmental variant of a "pelvic ear"¹ which was first thought to be the cause of increased uptake on the bone scan in Figure 1.

The outside bone scan (see Figure 3) performed 20 months prior showed intense increased activity at the left anterior superior iliac spine with additional

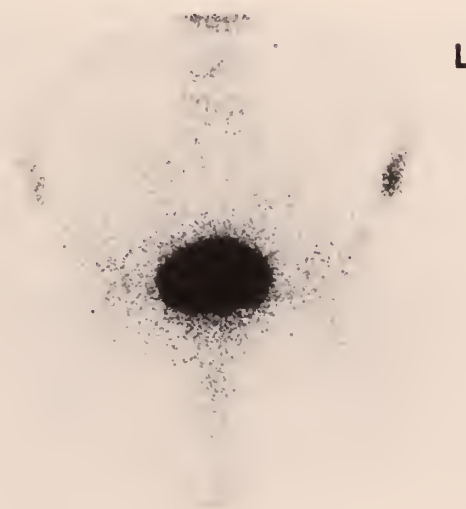


Figure 1. Bone scan performed at this admission.

"hot" spots in the rib cage, this picture leading to the conclusion that the area of increased focal activity in the left pelvis was in fact due to a metastatic bone lesion rather than a "pelvic ear."

This case illustrates once again that old studies are always invaluable and points out that normal

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Figure 2. AP pelvic radiograph.

variants such as "pelvic ears" are usually symmetrically developed;² therefore, increased unilateral uptake in the area should always raise suspicion. Also, "pelvic ears" are a fairly common development variant, and whether or not there would be increased uptake in the area on a normal scan is open to question.

★★★

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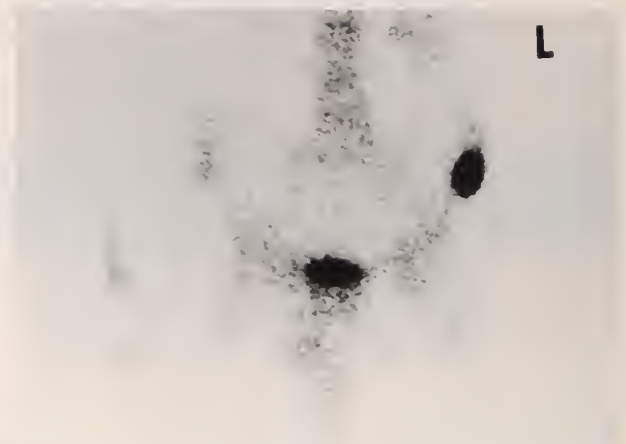


Figure 3. Earlier outside bone scan.

References

1. Keats, T. E.: *An Atlas of Normal Roentgen Variants that May Simulate Disease*. Chicago, Year Book Publishers, 2nd ed, 1979, p. 191.
2. Keats, T. E. (Theodore E. Keats, M.D., Radiology Department, University of Virginia Medical Center): Personal communication.

How to Be Sued Less Often and at Less Cost

HEBER A. LADNER, JR., J.D.

Jackson, Mississippi

THE TOPIC I have chosen — “How to Be Sued Less Often and at Less Cost” — capsules, I think, the current dilemma for the medical profession. The law has become an important consideration in medicine. It is unwelcome, but true. The quality of medicine practiced is important. Equally important, and my subject, is how a physician should structure and organize his procedures and approach in order to minimize risks. The critical considerations are patient handling, administration, handling of subordinates, physician/patient relationships, and fail-safe procedures in the medicine that is practiced. The future of medicine in the courts may be heavily predetermined and preordained by what physicians do in the office and in the hospitals henceforth. I will discuss what you can do to help yourself.

No one speaks of an absolute prophylactic on medical litigation. The numbers of unjustified suits predominate over the meritorious ones. There will be anesthesia-related deaths and disabilities; there will be statistical surgical complications in every specialty; there will be idiosyncratic reactions to medicines; and medical devices will fail or cause difficulty. As one astute physician has observed in response to a deposition question: “Sir, we have not been able to eliminate death and disability from medicine.”

My address to you is derivative, partaking of the best that I have heard and read from acknowledged experts in the field. I acknowledge a debt of gratitude to Lamar Reynolds, Bob Juraschek, Walter Eppes, and Jim Upshaw.

The framework for my talk is simple. I hope it will produce some self-analysis and criticism of the ways in which medical care is organized and rendered. I will cover (1) the perceived cause of suits; (2) why are suits won; (3) why are suits no worse than those won, lost; (4) claims mitigation, or how to help yourself and your lawyers; (5) risk prevention; and (6) a brief synopsis of how we stack up legally in Mississippi.

Cause of Suits

The way from your waiting room or hospital to a lawyer's office is longer than it seems. There are certain bridges over this chasm that deserve some attention. The first is that the physician generally is no longer held in the sacred position of respect he formerly enjoyed; the so-called “wall of silence” has totally collapsed, as there are many physicians making a practice of testifying against other physicians; there is a reservoir of legal manpower that has been forced into the malpractice field; the physician/patient relationship is weaker because of time pressure, bigger clinics and extravagant expectations from the wonders of modern medicine. Also, extravagant prognoses partaking of warranties or promises are often thought of as a cause. Alienation by fees and attendant collection efforts can also contribute.

Essentially what I am saying is that a bad result plus perceived inattention plus a decline of communication and contact between physician and patient lead inexorably to suits.

“Image” is over-rated, in my estimation, as a cause of suits. It may well explain jury behavior, but certainly not the generation of suits. Likewise, I think that mercenary motivation with the patient, as opposed to the lawyer, is not as high as we might imagine. The miracles of modern medicine and var-

Presented February 16, 1982, at Doctors Hospital, Jackson, Mississippi.

Mr. Ladner is an attorney with Upshaw and Ladner, of Jackson, MS.

ious provider payments are enforcing higher standards upon the medical profession. People expect more and are often disappointed.

Why Are Suits Won by the Doctors

There is a successful profile of a winning defendant. I do not intend to say that doctors themselves need to be doctored for courtroom presentation; rather, physicians tend to be independent, authoritative, and used to a position of power and authority. Without sacrificing these worthy traits, one may identify the profile of a winning medical defendant: (1) a humble, courteous attitude; (2) more considerate of the other lawyer than he is to you; (3) control of temper; (4) speaks in lay language (for juries will rarely vote and sympathize with someone they don't understand); (5) sensitivity to the human predicament; (6) does not apologize; (7) observes the fine line between pathos and expression of guilt; (8) firm conviction in the belief that the right medical steps were taken in light of what was known at the time and the applicable standard of care; and (9) an honest, aggressive, locally oriented defense.

Why Are Other Suits, No Worse Than the First, Unsuccessful in Court

Reasons include: (a) Bad medicine; (b) inadequate records; (c) inadequate attention to preparation; (d) need to expose expert witnesses and defendant-physicians to each other; (e) failure to determine all of the bad points and how to meet them; and (f) bad jury politics.

The prototype of a physician in court is the harried, preoccupied orthopedist who comes down to testify in a personal injury suit; he is taken out of turn; he looks at his watch; reads his medical reports; takes the attitude, "there it is, I said it, it must be true"; fields hostile questions on cross-examination with a more hostile attitude; and walks off the stand. The arrival and demeanor of the physician who has been sued must be one-eighty out. The physician who is successfully defended must also successfully defend himself, find himself at home with the courtroom environment, and pretend that he is happy to have a chance to set the record straight.

Withheld information, skeletons in the closet, or altered medical records are also a sure road map to doom.

Claim Mitigation

Once a claim is made, it is important for the physician to observe certain precautions.

First, remain silent and call your insurance car-

rier. They are professionals, know their business, and will guide you through these difficult waters.

Silence, no comment, and avoidance of comment out of school about the case will stand the physician in good stead. The trial will not be conducted in the hospital corridors, but rather, in the courtroom.

There should be no private agreement or alliances. Obviously, it is important to maintain courteous speaking relationships with subordinates and auxiliaries who may be involved in the case. This is good practice, but don't ask for favors.

Do not write the patient or his attorney refuting the charges. These letters invariably are damaging because they have largely been written without legal advice and deprive the physician of the flexibility he needs to tailor his position as the case moves along.

Physicians should promptly produce the medical records in keeping with a valid authorization. What should you send? Everything, every scrap of paper, which should not be edited. Why everything? The adverse inference from alteration or dry-labing of records outweighs any advantage that you can get from such conduct.

Improvement of the medical records invariably seems to road map the existence of a claim to the other side. Of course, there may be the temptation to add a line here or a line there on the theory that it was what you intended to write at the time. The problem with that memory exercise is that records get out of the hospital at different times; it is simply better to face the music of an omissive record than it is to explain an out-of-sequence entry. Adequate medicine but inadequate record keeping has made lawyers and doctors squirm in the courthouse.

Prepare your own private materials for litigation, scouring the hospital records, notes, and your memory for things that may fill out the record and guide your counsel. "If the chief of staff were reviewing this case, what would I want him to know about it in my favor."

Claim Prevention or Risk Management

I have seen many cases caused by subordinates and non-M.D. participants in medicine. There should be intelligent reliance on subordinates who tend to do things mindlessly and rote without comprehension of the consequences. "Miss X, this is 100 milligrams of what?"

Billing — a light pencil where the result has been bad is counselled; no unconscionably large bills. Also, repair previous mistakes free.

Take great pains and exertion, even at personal sacrifice, to try to help someone when arguably bad medicine produced the result.

Either personally or in your clinic or P.A. have the resources to finish everything you start or don't start it. Refer people you can't treat.

The over-extended physician is just as dangerous to himself as the incompetent, alcoholic, or aging physician, who are most frequently mentioned as vulnerable on liability.

Avoid prescribing or rendering medical treatment over the telephone. If the patient is in doubt, send him to ER and have someone see him.

Another dangerous aspect of the telephone message is handling of ER patients. If you have any doubt about the correctness of the information or the patient's condition, see the patient.

Post-surgery, seriously ill patients, ER patients call to mind a simple principle. See them, or have coverage to see them, consult, get someone to see them, or transfer them to ICU — (come, cover, consult or ICU). Calls from nurses or family should be a sufficient predicate to take action.

Fruitless efforts at collection of uncollectible bills can cause claims. Weigh the collectibility of the bill against the result of the treatment. It would take a very large outstanding claim for professional services to equal the time sacrifice in the expense of a claim. Establish your minimum amount below which it is not worth the trouble to pursue collection.

Intelligent, full record-keeping. Whether it is convenient or not, you are treating the records just as you are treating the patient. How often it is we, as lawyers defending the medical community, wish for more complete and accurate records in the early stages of hospitalization for acute illness and in the early post-surgical convalescence. This is where the action is. After all, if the result is bad or doubtful, the records should be good. They are Exhibit "A."

Should you have any doubts concerning surgical procedures, diagnosis or method of treatment, don't hesitate to seek another opinion. This protects you in case there should be some unfortunate eventuality.

Have a clear understanding that you are or are not turning the care of the patient over to a selected consult. Avoid Alphonse and Gadsden dilemmas. Follow the hospital bylaws for signing off a patient. If you admitted the patient, you are responsible for him.

Abandonment — among the most serious claims are claims of abandonment or neglect of a patient. Unless it is an emergency, the time to say no is the first time. If you are the patient's physician, provide access to a qualified substitute.

Practice on the margin of or outside your chosen specialization can be disastrous. Practice what you know and are comfortable with and refer or consult

on other problems.

The enlightened family practitioner should take a good, long look at referral whenever he has reason to believe that the results of a specialist are likely to be substantially greater than his own. Such a referral must be positive and unqualified, and the recommendation to see a specialist must be made very clear.

Informed consent — this is essentially a problem of communication — of advising the patient of his options and all reasonably accepted medical and surgical alternatives. All of the informed consent forms I have seen need revision, need topical reference to the specialty involved; in short, they need to be custom-tailored to the practice or procedure involved.

If you repetitively perform, as so many physicians do, certain types of surgery or procedures, it is not a bad idea to have a printed form explaining the type procedure involved. Then you can note on your records that you have given this to the patient and made yourself available to discuss it with him. The one or two surgical cases a year you lose because of the warnings will be more than made up for with peace of mind.

Avoid doctors' lounge consults and arm-chair generalship. It can get you sued.

Keep records defensively; avoid sandbagging or jousting with other doctors. Don't criticize others in the chain of delivery; don't confess in the records.

How Do We Stack Up in the Courts

Few medical cases reach the Supreme Court. Those that do, seem to bring adverse results. The present Court is a liberal court. Much of our medical malpractice law is left for future development.

We must concentrate on trying to win cases at trial. There is not too much likelihood of restrictive rulings on appeal.

One enlightened prediction is that we must anticipate a liberal ruling whenever a seriously injured person is involved.

To our advantage, we have a concentrated defense bar, intensifying and specializing its effort. On the other side, the plaintiff's bar is diffuse, cases are spread out; there are few plaintiffs' firms with any real concentration or experience in these cases.

Juries generally hold plaintiffs to a high standard of proof. This is counter-balanced against the jury's natural sympathy for the injured claimant and his difficulty in relating to the prosperous, well-educated physician.

One real problem is adverse newspaper publicity.

(continued on page 287)

Why Physician-Owned Professional Liability Insurance Companies?

C. G. SUTHERLAND, M.D.

Jackson, Mississippi

IN CONSIDERING THE EVOLUTION of various developments in our society, one often is inclined to meditate upon the whys and wherefores of same. Thus it was with this writer when considering the genesis of physician-owned medical malpractice insurance companies.

In no wise is this article intended to be an attack upon commercial insurance companies. Historically, they have had their faults as is true with all of us — but they have made and continue to make a tremendous contribution to society as a whole by offering protection to individuals against monetary loss by spreading the risk among a large group of insureds. That they make a reasonable profit as a result of these endeavors is not an indictment, but rather is consonant with one of the basic philosophical beliefs of most Americans. Capitalism and profit are not dirty words. One should be able to enjoy monetary benefits from his labors — or else we might as well be satisfied with a socialistic state of affairs and do as little as we can in order to survive.

It is a mistake then, to condemn commercial insurance companies for curtailing coverage or “pulling out of the market” as a result of the malpractice crisis of the mid 1970’s. The reason was very simple. Due to the highly unpredictable, explosive, and unacceptable quantum leaps in “pay outs” of malpractice claims, the field was viewed to be non-profitable and perhaps even uninsurable. No good businessman could be expected to continue to experience losses when all indications were more of the same, and when there were more stable areas to insure.

The charge has been made that the commercial carriers lost their money in investments, i.e., the

stockmarket, and were using this excuse to demand unconscionable increases in malpractice premiums. Perhaps some of these charges were true, but one only has to look at our current situation with *non-profit* physician-owned insurance companies to accept the fact that professional liability insurance is an unpredictable, highly explosive, increasingly expensive field of insurance.

The captive company of New York physicians is a good example. It has 18,000 members, 600 million dollars in assets, collects 180 million dollars of premiums annually, is a non-profit organization, and still has experienced a steady increase in premiums since its inception in 1975. It now is asking approval for another 52% increase in order to adequately cover its payout liabilities. If granted, some doctors in the highest risk categories who now pay \$36,000 a year in premiums, will pay over \$50,000 a year in premiums. The other major carrier in New York State (JUA) has asked for a 200%+ increase — and, if granted, a neurosurgeon would pay \$125,000 a year for coverage.

Since the inception of MMFES in 1977, it has been found necessary to increase premiums over 100% based upon actuarial advice. These increases are necessary in order for our company to remain solvent. There is a dramatic increase in the number of claims, size of judgments or settlements, and costs of defense — with inflation playing a major role. Even the uninitiated can understand that if one has assets of \$10,000,000 but is faced with a potential payout of \$12,000,000 in the next few years, as all these claims come to fruition, one is not necessarily in a desirable financial posture. Hence the necessity for adequate reserves in order to meet potential losses.

One of the finest words in our dictionary is “competition.” For this reason alone, this writer is anxious to see commercial insurance coverage available to physicians in the State of Mississippi, if they so choose, after comparing the pros and cons of being insured with MMFES.

Dr. Sutherland is medical director of Medical Assurance Company of Mississippi. Prior to August 1, 1982, the company was known as Mississippi Medical Fraternal and Educational Society (MMFES).

In the mid 70's, some states were faced with the fact that professional liability coverage for physicians was becoming more difficult to obtain or indeed, had become unattainable through commercial sources. Many companies withdrew or curtailed their underwriting activities in this area. Reasons might be said to include demands for premium increases that were totally unacceptable to the physicians or insurance commissioners, failure to be allowed to write "claims made" policies rather than "occurrence" policies, and a marked increase in the number of claims and the cost involved to resolve these claims. Some few companies went into receivership due to lack of adequate funding. Regardless of the etiology, the fact remains that because of this exodus (and the degree of exodus varied from refusal to write new business to refusal to write any business), some states were faced with a true "crisis of availability."

Mississippi did not experience this crisis of availability, but the fact that there was only one carrier in the state, and that carrier was reacting to the "national malpractice crisis," encouraged our Mississippi State Medical Association to create our physician-owned society which began business in 1977.

A funny thing happened on the way to determining which insurance companies withdrew from the market or curtailed their underwriting activities in medical malpractice as a result of the "malpractice crisis" of the mid 70's. We could find no central source that has this information. Our search included inquiries to such sources as the AMA, the Mississippi Insurance Commission, and the National Association of Insurance Commissioners. All agreed that "many cut back and some withdrew entirely," but they had no record of whom and to what degree. As a result of this dearth of available information, a poll was taken of all state medical societies as well as all physician-operated insurance companies. Below is an abbreviated sample of the letter used in the survey:

Gentlemen:

As Medical Director of the Mississippi Medical Fraternal and Educational Society (a physician-owned professional liability insurance society sponsored by the Mississippi State Medical Association), I am interested in a survey to determine which commercial companies, if any, decided to discontinue or curtail the underwriting of malpractice insurance for physicians in your state during the malpractice crisis of the mid 70's. (etc.)

The following is a summary of the responses. Admittedly, some inaccuracies may exist — if so, proper retraction will be made upon notification.

Alabama — USF&G, Aetna, Continental, INA.

GNA, Employers of Wausau, St. Paul

Alaska — Dawson & Company, Aetna, INA, Manufacturers and Wholesalers

Arizona — Travelers

California — American Mutual, Travelers, Pacific Indemnity, Imperial, Casualty Indemnity Exchange, Signal, Hartford, Argonaut

Connecticut — St. Paul, Hartford, Travelers, Lloyds

Delaware — none

District of Columbia — none

Florida — St. Paul, Argonaut, USF&G, Hartford, CNA, Signal, Imperial

Georgia — none

Indiana — St. Paul, Hartford, Argonaut, Travelers, and several others

Illinois — St. Paul, Hartford (lost State Medical Society sponsorship via unacceptable rate increases, but did not cancel its program)

Iowa — none

Kentucky — Travelers, Continental, INA, Medical Protective of Fort Wayne, Indiana, Aetna (as best the respondent remembers)

Maine — none

Maryland — St. Paul

Michigan — Shelby Mutual, St. Paul, Argonaut, Aetna, Medical Protective

Missouri — USF&G, Medical Protective, Aetna, St. Paul

Nebraska — Aetna, Hartford

New Mexico — Travelers, St. Paul, Aetna, USF&G

New York — Argonaut, Employers Insurance Company of Wausau, Wisconsin

North Carolina — St. Paul, Aetna

North Dakota — St. Paul, Aetna, Hartford

New Jersey — St. Paul, Aetna, Travelers, INA, Chubb (In 1977, no single commercial carrier was willing to write professional liability insurance. A JUA was in effect)

Nevada — Imperial, Casualty Indemnity Exchange, Argonaut

Oklahoma — Travelers

Ohio — Med Pro, Shelby Mutual, St. Paul, Argonaut, Hartford, Buckeye Continental, Aetna

Pennsylvania — Aetna, Travelers, INA, St. Paul, USF&G, Argonaut

Rhode Island — In April, 1982, a class action anti-trust suit by 600 doctors against St. Paul, Aetna, Hartford, and Travelers was settled out of court for 1.1 million dollars. The suit was filed in 1975,

seeking 100 million dollars, with the doctors alleging that the insurance companies had refused to sell them coverage for a time that year. The case was argued before the U.S. Supreme Court, who sent the case back to the District Court for trial. An out of court settlement was reached prior to trial.

South Carolina — St. Paul

South Dakota — none

Tennessee — Shelby Mutual, St. Paul, Aetna, Cincinnati, Hartford, USF&G. In the mid 70's, one company, Shelby Mutual, dominated the malpractice market in Tennessee. When Shelby Mutual announced they would withdraw from the market by the end of 1975, the Tennessee Medical Association could not find a single company to provide coverage for Tennessee physicians. As a result, the State Legislature passed a statute requiring all casualty insurance companies to participate in the Tennessee Temporary Joint Underwriting Association. On September 1, 1975, the JUA became the sole provider of physician malpractice insurance. In 1976, the State Volunteer Mutual Insurance Company (physician-owned) was formed and the JUA was discontinued. St. Paul announced that they would pick up those doctors whom they had insured in the past with the exception of anesthesiologists. Currently, St. Paul actively solicits physicians, including anesthesiologists, and is the only competitor or SVMIC. In 1979, Tennessee enacted a statute requiring that all insurance companies who issue malpractice insurance to physicians licensed to practice in Tennessee shall issue policies covering physicians in all classifications of practice.

Utah — St. Paul, Travelers, USF&G

Vermont — none

Virginia — Aetna, Travelers, USF&G

Washington — Argonaut, St. Paul

We did not get a 100% response to our letter written on April 13, 1982, but did receive answers from 34 states plus the District of Columbia. This should give a valid overall view of the situation at that time.

Interestingly, Florida, Maryland, New Jersey, and Tennessee could not find a single carrier interested in writing or continuing to write professional liability insurance in their states during this time. The extent of this situation over the country as a whole was not determined by this survey. In at least one state, Pennsylvania, the Argonaut Insurance Company stayed until 1978 as a result of legal action by the Pennsylvania Medical Society holding the company to a five-year contract.

As a result of this crisis in availability of malpractice insurance for physicians, 33 states passed statutes authorizing the creation of a Joint Underwriting Association, if needed, and 6 states passed statutes creating a JUA as an exclusive agency. (A JUA is a mechanism whereby all commercial liability insurers in a state are required to participate, via a pooling arrangement, in which professional liability insurance must be offered to physicians.)

Also, as a result of this crisis in availability, physician-owned liability insurance companies were formed. Maryland was the first and they began business on June 3, 1975. As of June, 1982, the Physician Insurers Association of America has 29 member companies with Louisiana and Georgia being the most recent new members. PIAA companies insure over 110,000 physicians (43% of the market) and has total combined assets exceeding 2.5 billion dollars.

In recent times, many commercial carriers have re-entered the physician professional liability field. Basically, one can only presume that this is so because of the belief that the business has again become reasonably predictable and profitable. Premium dollars can be invested at an unheard of rate of interest; all states passed statutes intended to help alleviate the crisis (over 500 statutory changes, total, between 1975 and 1980); risk management activities have intensified with better education of physicians concerning their legal exposure; and the use of claims made policies which theoretically should reduce the "long tail" exposure and allow for more accurate actuarial determinations.

Other than solving the availability crisis, what can one say as to the attributes of the Mississippi physician-owned liability company? Listed below are some of the advantages, at least as far as this writer is concerned:

1. With proper management and realistic underwriting, which we have, this company can and will remain in the business as long as commercial companies do.
2. Policyholders are *stockholders* and have access to direct input in determining company policies.
3. Non-profit status results in savings with regard to premiums.
4. Sponsorship, close association, and cooperation with its parent organization, MSMA, and the many advantages that MSMA offers its membership.
5. Company policy precludes settlement of a case without permission from the defendant doctor,

thus placing the doctor's reputation above monetary considerations.

6. A Claims Committee of physicians who give invaluable service to review of cases.
7. A Risk Management Committee of physicians who make recommendations for improvement to the Board of Directors.
8. A physician education program designed to reduce exposure.
9. Active support, including monetary support, of the Disabled Doctors Program of Mississippi.
10. A full-time, well trained staff that is readily and easily accessible to policyholders for any assistance they can offer.
11. Membership in the Physician Insurers Association of America (composed of 29 members, each having the sponsorship of organized medicine in their state) where information in all aspects of the business is exchanged.
12. A Board of Directors, all physicians and all policyholders of MMFES, elected by and responsible to the membership. The Board makes policy decisions as to what is best for the doctors in Mississippi. Annual actuarial review is based solely on Mississippi experience.
13. A basic philosophy that this company was formed, in addition to availability, for (1) protection of the doctor, (2) protection of the patient (some mal-results should be compensated), and (3) improvement of medical care.
14. Service is our credo.

In the beginning, physician-owned companies were derisively referred to as "bedpan mutuals" with their early demise predicted. This term is still used by detractors, but one gets the impression now that the term is used in more subdued, respectful tones and perhaps "bedpan" is even spelled with a capital "B."

Even though the availability crisis seems to have been solved, an "affordability" crisis is at hand and apparently is intensifying. After yearly premiums reach a certain level, it is totally unrealistic to think that physicians can continue to pass on these increased costs to the patient. As one physician observed, "the level of malpractice premiums in some areas has become absurd and even obscene — there is a limit to what society can afford in this regard." In an effort to help alleviate this affordability crisis, MSMA and MMFES plan to attack the problem in Mississippi from three standpoints:

1. Legislative relief via tort reforms
2. Education of the public as to what the situation is and what it is costing everyone, and
3. Continued education of physicians in the field of legal medicine.

If your two societies call upon you individually for help in this regard, please be supportive and participate. Our failure to control costs could well result in some form of governmental control similar to workmen's compensation or no-fault insurance.

★★★

P.O. Box 4625 (39216)

How to Be Sued Less Often And at Less Cost

(continued from page 283)

It seemed that years ago newspapers vied to report the biggest freeway pile-up or the latest juicy criminal story. Now the press seems to focus upon the size of the latest jury award for hypoxic brain damage in the United States. All of them may condition the expectations of plaintiffs and the mentality of jurors. Adverse newspaper publicity is not the end of it. The opening episode of the television serial, "Nurse," concerned a physician whose hands uncontrollably shook during surgery and he mangled a gall bladder. They covered it up but got him off the staff.

One principle is abundantly clear. All of the "hired guns" and \$1,000-a-day witnesses cannot begin to override the personal, life-long friendships many of you will have with the local jurors. I recall one juror who stated during impaneling, "No, I cannot hear that doctor's case. He saved my mother's life." We had some good proof, but that was probably the best proof we had.

So long as we have the jury system, an expert witness from the town or county where the defendant lives, who is well thought of, will be more availing than all of the hired testimony from national medical centers elsewhere.

★★★

1675 Lakeland Dr. (39216)

PROFILES

Joe Burnett Trustee, District 2

Anyone familiar with the state of Mississippi is undoubtedly aware that the city of Oxford is the home of the University of Mississippi and the birthplace of author William Faulkner. While a university or a famous citizen may give a community its particular distinction, it is the individuals within the community which give it its *life* — people who work at their jobs, raise their families, and participate in and contribute to the community's activities.

Dr. Joe Burnett of Oxford is typical of such a citizen. By his own admission, his professional activities and family interests occupy most of his time. The term professional activities, as anyone who knows much about doctors' lives can state, is not limited to seeing patients in the office or hospital (although in most cases that alone could fill a calendar). And in our fast-paced society, a family that includes four energetic children can generate enough activity to fill another calendar.

Whenever he has some time to spare, Dr. Burnett is likely to spend it enjoying his primary hobby of duck hunting, usually in the Mississippi Delta or in Arkansas. He has been area chairman of the Sardis Lake Chapter of Ducks Unlimited, and he has also served as district chairman of the organization.

Joe Burnett, a Charleston native, has been married since 1961 to the former Martha Kathryn Grant of Grenada. Their children are Elizabeth, a sopho-

more at Ole Miss; Margaret, a junior in high school; Jay, a 10th grade student; and Kathryn, a 9th grader. Whenever possible the Burnett family enjoys traveling, and their trips have taken them in recent years to Disney World, Pickwick Lake, Washington, DC, and Colorado. The Burnetts are active members of First Presbyterian Church of Oxford, where Dr. Burnett has served on the Session.

The Burnett family's home is characteristic of another distinctive feature of Oxford — its old Southern architecture. But the Burnett home may be unique in one respect — it once stood in Grenada. Though they lived in Oxford, the Burnetts admired the Grenada house, an early Louisiana cottage style home built in the early 1860s. When the house was offered for sale, they purchased it. While they did not move the house as such, they built an identical foundation and frame on their homesite in Oxford, and virtually reassembled the Grenada house, complete with its 14-foot ceilings, original heart pine floors, all original woodwork, doors and windows, and mantels for the five identically reproduced fireplaces.

Like many young people, Joe Burnett says, he had his idols. One of those was Dr. E. W. Ryan, a Charleston family physician. His respect and admiration for Dr. Ryan, along with his desire to embrace a profession which offered such opportunity for service, led him to choose medicine as a career. It was this same interest in being of service which also led him to return to his native North Mississippi to practice, because he saw an opportunity to fill a need.

Since opening his otolaryngology practice in Oxford in 1974, Dr. Burnett has been active in many related professional organizations, including North Mississippi Medical Society, the American Medical Association, the Mississippi Foundation for Medical Care, the American College of Surgeons, the American Academy of Facial Plastic and Reconstructive Surgery, and the Mississippi EENT Association, to name just a few. In 1980 he was appointed by Governor William Winter to a three-year term on the State Council of Advisers in Speech Pathology and Audiology. Since 1979 he has served as a trustee of the Mississippi State Medical Association, representing District II.



First in a series featuring members of the MSMA Board of Trustees

Virginia Tolbert Trustee, District 1

Throughout the past decade Dr. Virginia Tolbert has been the subject of a number of feature articles in magazines and newspapers, most of them focusing on the varied interests and accomplishments of this busy woman physician.

When she was elected last May as the first woman member of the MSMA Board of Trustees, it was another in a long list of "firsts" for "Dr. Virginia," as she is referred to by many citizens of Ruleville, where she has practiced for some 32 years.

She began her habit of accomplishment at a young age. She was the youngest person to graduate from Ruleville High School (she was 14 and was valedictorian of her class). Both her parents were college graduates, unusual for that time, and she says it was just always understood that she and her sister Mary would go to college — even though it was a time during the worst of the Depression) when few people were going to college, and especially few women. She graduated magna cum laude from Mississippi State College for Women (now Mississippi University for Women), and later she received her M.D. degree from the University of Tennessee College of Medicine (she was first in her class).

A lifelong interest in politics led her to a successful race for a post on the Ruleville Board of Aldermen in 1970, and in 1973 she was elected mayor and became the only woman mayor of a Mississippi city at that time. Her interest in politics, as in education, came about largely through family example. Her father, Horace Stansel, was Speaker of the House of Representatives, and when he died Mrs. Stansel assumed his seat and later was elected to an additional term.

Dr. Tolbert says she always wanted to be a doctor and has found it to be a very rewarding profession. Responding to a comment by one interviewer on the range of her interests and the number of her accomplishments, she once remarked, "I believe everyone must pay his way on this earth by doing his bit for his fellow man and for his community."

The awards and honors which have come her way have paid tribute to the fact that Dr. Tolbert has, indeed, "done her bit." She received the MSMA/



Robins Award for Community Service in 1974. In 1975 McRae's department stores designated her as one of Mississippi's "Beautiful Activists." The Mississippi Federation of Business and Professional Women's Clubs named her "Woman of Achievement" in 1975. If she has a favorite public service organization, she says, it would be the Sunflower County Heart Association, an organization which she has served in many capacities, including president, through the years.

Dr. Tolbert's hobby is collecting cut glass pieces, and she has an extensive collection. Her interest in the art developed when she inherited a few pieces some 25 years ago, and she has continued to add to the collection.

Whenever she is not busy with her many activities, she enjoys traveling with her husband, Dr. Earl Tolbert, a dentist. Last year they traveled to the South Pacific, visiting four places where her husband was stationed during World War II. This fall they plan to spend a month traveling in Florida. The Tolberts also enjoy spending time with their family, which now includes four grandchildren and three great-grandchildren.

Dr. Tolbert has long had a special interest in rural health concerns, particularly the need for more family physicians in rural areas. She has devoted much time to other health concerns such as the need for health education and the problem of drunk drivers. (She is currently actively involved with MSMA's Committee on Drunk Drivers.) She recently resigned as medical director of Parchman Penitentiary and has limited her Ruleville practice. But people who know her expect her to continue at her usual energetic pace, undoubtedly spending even more time serving in professional and related organizations which address her particular concerns.

MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 19-23, 1983, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610

State and Local

Mississippi State Medical Association, 115th Annual Session, May 11-15, 1983, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, July 6-9, 1983, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39221.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 3rd Wednesday, January, May, and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. J. Barry Gilbert, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Robert L. Coggin, Pres. and Secy., 965 Avent Dr., Grenada 38901. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, State, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March,

June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Albert H. Laws, Secy., 816 Second Ave. North, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, June, September, December. Robert D. Holbert, Secy., P.O. Box 1502, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Douglas F. Thomas, Secy., 415 South 28th Ave., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly
Mississippi State Medical Association
735 Riverside Drive
Jackson, MS 39216

North Mississippi Medical Center
830 Gloster Avenue
Tupelo, MS 38801

Forrest General Hospital
Box 1897
Hattiesburg, MS 39401

Mississippi Baptist Hospital
1225 N. State Street
Jackson, MS 39201

Gulf Coast Community/Gulfport
Memorial Hospital Consortium
4642 W. Beach Boulevard
Biloxi, MS 39531

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Delta Medical Center
Greenville, MS 38701

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Biloxi Regional Medical Center
1559 Lafayette St.
Biloxi, MS 39533

Mississippi Radiological Society
316 Medical Arts Building
Jackson, MS 39201

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

Mercy Regional Medical Center
100 McAuley Drive
Vicksburg, MS 39180

North Panola County Hospital
Drawer 160
Sardis, MS 38666

Singing River Hospital
2809 Denny Avenue
Pascagoula, MS 39567

Magnolia Hospital
Alcorn Drive
Corinth, MS 38834

Greenwood Leflore Hospital
1508 Leflore Avenue
Greenwood, MS 38930

South Washington County Hospital
Drawer 398
Hollandale, MS 38748

Mississippi State Medical Association Auxiliary

Shaping Our Future

"Shaping Our Future," our auxiliary theme for this year, offers an interesting springboard for a variety of activities. This particular theme was chosen not only for its flexibility, but also because it expresses the increasing sentiment among auxiliaries that, as a part of the medical community, we need to intentionally prioritize our year's objectives.

It's important to us that the association is aware of our specific plans. To implement the "Shaping Our Future" concept, the Auxiliary has chosen six major objectives for the year.

First, we want to increase numbers and participation in MSMA Auxiliary in 1982-83. More specifically, we intend to increase membership by 10% and organize at least three new county auxiliaries. Membership is one area in which you physicians can really assist us. If your spouse is not a member, insist that he or she join. If your county or community doesn't have an active auxiliary, let's reactivate or organize one.

Our second objective is to spark a greater awareness and participation in the legislative process. To help us reach this goal, Bucky Murphy, MSMA's legal counsel, will lead a workshop entitled "Legislative Preview" at our Fall Workshop on October 26. Also, the Auxiliary will join the MSMA in a leadership training/political action workshop in March.

A third objective is to make every auxiliary member aware of the Impaired Professional Program and to actively support it. As a result of a June Board Meeting discussion exploring avenues for greater auxiliary involvement in the program, a workshop has been scheduled for November 9. Dr. D. P. Smith, director of the program, will train a select group of auxiliaries interested in serving as support persons for families with an impaired member. A public forum on chemical dependency is considered another possible avenue for auxiliary involvement.

Fourth, the Auxiliary recognizes the need to be image-builders for medicine. Two goals to achieve this objective are the development of a "Shape Up for Life" brochure for distribution through physicians' offices and promotion of the Burroughs-Wellcome health information radio interview program.

Fifth, a complete bylaws revision is called for this year. That speaks for itself!

Finally, the Auxiliary will encourage each county auxiliary to continue the "Shape Up for Life" emphasis, as a way of cutting medical costs by promoting healthy lifestyles.

If you've gotten the idea that auxiliaries are busy people, you're right! We're welcoming new physicians' families to town, confronting issues, affecting the legislative process, working on health projects, raising funds for AMA-ERF, and presenting health-related programs in communities all over the state — and all in the name of medicine!

Shaping Our Future,
NANCY MARTIN
MSMA Auxiliary President





The President Speaking

There'll Be Some Changes Made

SIDNEY O. GRAVES, JR., M.D.
Natchez, Mississippi

Last month, on this page, I told you of the organization and the agenda of the Committee to Study MSMA Reorganization. The committee has met once and will meet again shortly. I am both appreciative and impressed by the fact that all members of the committee were present. To me that is a real indication of a conscientious group.

Although the committee discussed several items, I want to specifically report to you the discussion concerning the Scientific Program Format. We now have fourteen MSMA Scientific Sections, each of which holds a scientific meeting and usually a business or social gathering of its related state specialty society at each annual session. Further, MSMA pays the expenses for two out-of-state speakers for each section; and attendance at the section meetings varies from commendable to embarrassing. These facts should explain why we must change. The logistics and the expense have become overwhelming; we are also apparently trying to hold too many scientific meetings based on the available audience. Some of the considerations by the committee are:

- A program chairman elected by the House of Delegates for each MSMA Scientific Section. This would be through the nominating process from names submitted by each specialty group.
- Each MSMA Scientific Section will be placed in either a medical or surgical group.
- The large groups (Medical and Surgical) will each be responsible for planning one-half day plenary sessions.
- Responsibility as planning leader will rotate annually among members of the group.
- Current and future MSMA Scientific Sections must be composed of at least 80% MSMA members.
- The state specialty societies will be encouraged to hold business and social occasions as they do now.

There are other considerations which must be examined, but I feel that this is a good beginning. The House of Delegates should have much to consider at the 1983 Annual Session. Plan to attend and enjoy the festivities. ★★★

Two Alternatives

Both our MSMA and AMA presidents, in their annual addresses to the state delegates, were primarily concerned with health care cost containment. The latter mentioned the percentage of health care dollars spent for preventable or self induced conditions, such as the results of alcohol and tobacco.

The public is better informed today than ever before about the evils of both. Further education might help but probably would not be cost effective. However, we continue to see beautiful ads in magazines depicting the pleasures of smoking and drinking and suggesting sensuality in both cases. These might be discouraged. Certainly PSROs have some impact by prohibiting excessive utilization.

It seems almost naive to me to expect the medical profession to contain costs to any appreciable degree. I rarely see any evidence that the medical profession is responsibly addressing its obligation when there is no quality of life salvageable.

We can reasonably expect the demand for medical service will only increase as our elderly population increases.

In the final analysis we have two alternatives:

1. Decrease the coverage furnished by third parties, thus requiring a larger proportion of payment from recipients. In no case should first dollar coverage be allowed. This applies to Medicaid as well.

2. A national health insurance similar to Canada's, which furnishes some of the most comprehensive and extensive services in the world at a cost of 7.3% of its GNP. At present costs in the United States are approximately 9.8% of GNP, and unless some curbs occur, they may well exceed 10% next year.

Canada has achieved this amount of health care at its price by a phenomenon referred to as "under

funding." In essence, so much is allowed and purveyors are required to "make do." Elective admissions are frequently postponed for several months and medical staffs don't always have ready access to body scanners, computerized angiography or other equally expensive modalities. By and large however the quality of care is good.

Lest the medical community in this country complacently feels that the public would not stand for this, let them be aware that national health is a sacred cow in Canada, and a politician who proposes anything less commits political suicide.

Opponents cry that quality of care is being compromised and that access to care is often too slow. However, most everyone seems happy except the doctors.

W. MONCURE DABNEY, M.D.
Editor

At some time each of us will probably visit the country doctor's office at the Agriculture Museum. To date it is not funded. I realize that we are besieged daily for contributions to some cause or other, but we alone are responsible for this particular project. If each physician would contribute only \$20, our funding problem would be over. Please help. You'll be glad you did when you see it. — W.M.D.

MEDICO-LEGAL BRIEF

Death Claim from Laetrile

A trial court erred in granting summary judgment for a physician in a malpractice suit charging him with negligence in administering laetrile, pangamic acid, and wobenzyme to a terminal cancer patient, a Georgia appellate court ruled.

The patient had her uterus removed, and the final diagnosis was a mullerian tumor (carcinosarcoma) with probable vascular invasion. In early October 1977, she began to have further intestinal complaints. He treated her with Valpin with phenobarbital, Thorazine, and Empirin. He consulted with her surgeon, who had consulted with a radiologist and oncologist, and was advised that there was no chemotherapy or radiotherapy available to treat her condition.

The physician said he fully explained to her the prospect of treating her with nutritional therapy and laetrile. She consented, and he began intravenous administration of laetrile on a regular basis. She died five weeks later of acute kidney failure due to metastatic carcinosarcoma of the uterus.

The patient's children sued the physician for medical malpractice, alleging that the laetrile and nutritional therapy were the sole cause of her death. A trial court granted summary judgment for the physician, and the children appealed.

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Reversing the trial court's grant of a summary judgment, the appellate court said that there were issues of material fact that needed to be resolved. The court noted that the use of laetrile was highly controversial and that laetrile was only available for investigational use. There was expert medical testimony that a general practitioner like the physician was not competent to treat a patient for cancer and that he did not take the necessary diagnostic steps.

Additional medical testimony indicated that laetrile contained cyanide and other toxic substances that could have contributed to the death of the patient, the court said. — *Sullivan v. Henry*, 287 S.E.2d 652 (Ga.Ct. of App., Jan. 5, 1982)

RECOLLECTIONS

The October 1962 issue of JOURNAL MSMA reported that Central Medical Society had welcomed home medical officers who were called up during the Berlin crisis in October of 1961. The group included: Col. David B. Wilson of Jackson, commander of the 134th Mississippi Surgical Hospital Unit; Lt. Col. Carroll L. Busby of Whitfield; Capt. William M. Flowers of Jackson; Capt. McWillie M. Robinson of Jackson; Maj. Clinton E. Wallace of Jackson; Lt. Col. Thomas K. Williams, Jr., of Jackson; Capt. Carl G. Evers of Jackson; Capt. Wayne P. Cockrell of Magee; Capt. Charles H. Martin of Whitfield; Capt. Daniel E. Merck of Jackson; Capt. W. H. Merrell of Jackson; and Capt. Robert P. Myers of Jackson.

In the same issue it was reported that preliminary plans had been approved for the proposed \$3,750,000 Hinds County Hospital, and that the 220-bed facility was expected to open some time in 1965.

The JOURNAL reported that Dr. J. P. Culpepper, Jr., of Hattiesburg, AMA vice president, was scheduled to be one of the speakers for a Chicago meeting, "Survival in the Sixties." The symposium to review medical preparedness in the U.S., Canada and Europe was being sponsored by the AMA's Council on National Security.

Scientific articles included: "Preanesthetic Evaluation of the Poor Risk Patient," by Marion A. Carnes, M.D. and Leonard W. Fabian, M.D., of Jackson; "Differential Diagnosis of Chest Pain," by David J. Van Landingham, M.D., of Jackson; and "Pulmonary Histoplasmosis," by Robert P. Henderson, M.D., of Jackson.

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Prescribe for your patients as you would for yourself.

*Write "D.A.W.," "No Sub," or "Medically Necessary,"
as your state requires, to make sure
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ONE OF THE VITAL SIGNS OF ANXIOUS DEPRESSION: INSOMNIA

Others to look for:

agitation

anorexia

feelings of guilt
and worthlessness

fatigue

palpitations

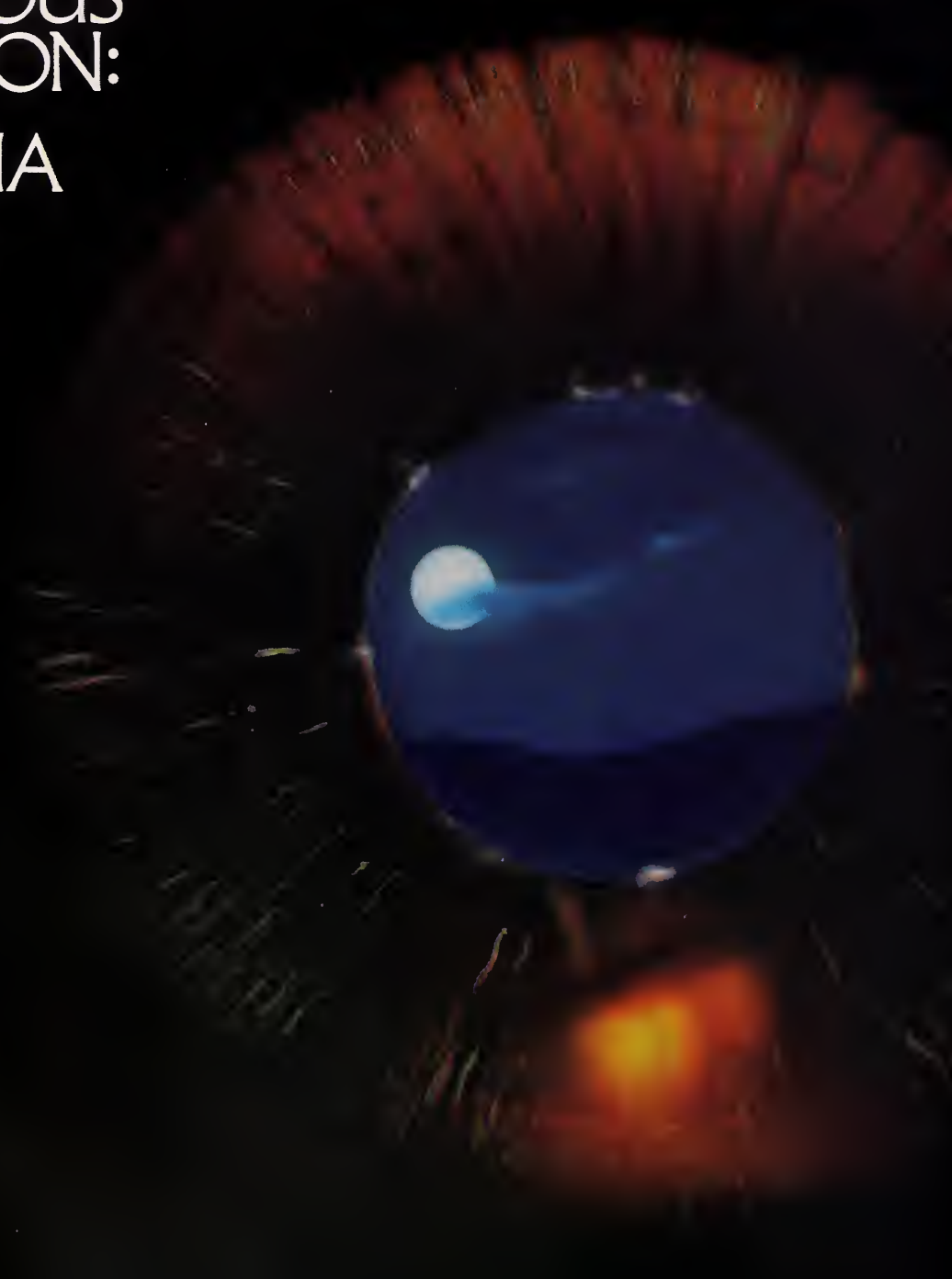
headache

vague aches
and pains

sadness

psychic and
somatic anxiety

Artist's conception,
looking out from the human eye
as conceived in a schematic model.



LIMBITROL GIVEN H.S.: ONE OF THE VITAL SPECIFICS OF TREATMENT

Limbitrol brings a special—and specific—quality of relief to most anxious depressed patients. Insomnia, for example, responds with particular promptness. Other symptoms likely to respond within the first week of treatment include anorexia, agitation and psychic and somatic anxiety. And, as the depression and anxiety are alleviated, in many cases so are such related somatic symptoms as headache, palpitations, and various vague aches and pains.

Limbitrol given once daily h.s. may be the best approach

Many patients respond readily to a single bedtime dose of Limbitrol, a convenient schedule that may enhance compliance and helps relieve the insomnia associated with anxious depression. Limbitrol also offers a choice of other regimens: t.i.d., or a divided dose with the larger portion h.s. In all cases, caution patients about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as driving or operating machinery.

in moderate depression and anxiety

Limbitrol® IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline
(as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline
(as the hydrochloride salt)

Specific therapy with h.s. dosage convenience

Please see summary of complete product information on following page.

LIMBITROL® TABLETS Tranquilizer—Antidepressant

Before prescribing, please consult complete product information,

a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses.) Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence on chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extropyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks of 50.

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POSTGRADUATE CALENDAR

Oct. 29, 1982

FLUID BALANCE AND NUTRITION IN THE NEWBORN
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Pediatrics Division of Newborn Medicine and the Medical Center Division of Continuing Health Professional Education.

Coordinator: Philip G. Rhodes, M.D., UMC associate professor of pediatrics and newborn division chief.

This course will define normal electrolyte and nutritional needs of high risk newborn. Parameters for evaluation of nutritional support and immediate and long-term evaluation management are included. Fee: \$35. Credit: 5 contact hours (.5 CEU) Category I, AMA; AAFP.

Nov. 2, 1982

MISSISSIPPI THORACIC SOCIETY MEETING AND BOSWELL LECTURE
University Medical Center, Jackson

Sponsored by the Mississippi Lung Association, the Mississippi Thoracic Society, the University of Mississippi School of Medicine Department of Medicine Pulmonary Division, and the Medical Center Division of Continuing Health Professional Education.

Coordinator: Jerald Jackson, M.D., Hattiesburg

This program offers the primary care and specialty clinician a review of the pathophysiology, diagnosis and treatment of thromboembolic disease. The Boswell Lecture will present the latest concepts in thrombolytic therapy. Fee: \$10. Credit: 5.75 contact hours (.57 CEU) Category I, AMA.

Nov. 5-7, 1982

UROLOGY VISITING PROFESSOR
Diamondhead Resort, Bay St. Louis

Sponsored by the University of Mississippi School of Medicine Division of Urology, the Mississippi Urological Society and the Medical Center Division of Continuing Health Professional Education.

Coordinator: Lamar Weems, M.D., professor of surgery (urology) and chief of the division of urology, University of Mississippi School of Medicine.

This program will focus on recent advances and modern techniques in urology. Guest lecturer is Lester Persky, M.D., a private practitioner from Cleveland, Ohio. He is clinical professor of urology at Case Western Reserve University. There is no registration fee for members of the Mississippi Urologic Society. Credit: 8 contact hours (.8 CEU), Category I, AMA.

Dec. 9-10, 1982

PERINATAL POSTGRADUATE COURSE
Holiday Inn Downtown, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Obstetrics and Gynecology Division of Maternal-Fetal Medicine, the Department of Pediatrics Division of Newborn Medicine, the School of Nursing and the Medical Center Division of Continuing Health Professional Education.

Coordinators: John Morrison, M.D., professor of obstetrics and gynecology and director of the division of maternal-fetal medicine, and Philip G. Rhodes, M.D., associate professor of pediatrics and chief of the division of newborn medicine.

This course will focus on the diagnosis and management of the high risk parturient and neonate. Ethical issues in the care of the seriously ill and genetic counseling will be covered. High risk areas such as prematurity and chronic hypertension in the mother and infection and metabolic disturbances in the neonate will be included. Fee and credit to be announced.

For information on these and other continuing education courses, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone: (601) 987-4914.



Famous Pairs.

*They work so
well together.*

One of man's most amazing explorations and scientific adventures, the successful Gemini flight program was a triumph of imagination and teamwork. Two men learned to operate in space, to rendezvous, to dock, and to work outside their spacecraft in the hard vacuum of outer space. Not only did they coordinate their efforts with ground backup, they also complemented each other's activities within the close confines of the space capsule.



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...another well-known pair that works so well together! Ninety-five percent of colon/rectal surgeons surveyed* added Tucks pads concomitantly to hemorrhoidal treatment programs they recommended.



Anusol-HC[®] Suppositories/Cream with Hydrocortisone Acetate

The #1 physician-prescribed product for hemorrhoids and other common anorectal disorders**

- ☐ Antiinflammatory, to relieve edema, burning, itching, pain
- ☐ Astringent, to help promote healing
- ☐ Emollient, for easier bowel movements and soothing relief of local trauma

And, when pain is a special problem, Anusol Ointment offers the benefits of the anesthetic, pramoxine HCl.

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Pre-Moistened Hemorrhoidal/Vaginal Pads

The #1 hemorrhoidal pad* for added external relief and gentle cleansing of fecal residue

- ☐ Soothes, cools, comforts the irritation and itch of hemorrhoids and other common anorectal disorders
- ☐ Hygienic rectal wipe—an integral part of the anorectal regimen

Once pain and inflammation subside, for dual action recommend regular ANUSOL[®]—to maintain patient comfort—and TUCKS[®]—to maintain patient anorectal hygiene.

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**WARNER
LAMBERT**

* Meeting of Am Soc Colon/Rectal Surgeons, May 1980.

** Based on total prescriptions filled for hemorrhoidal preparations during the first three quarters of 1981. The National Prescription Audit, IMS America Ltd., Sept 1981.

* 1981 data from leading marketing research organization.

ANUSOL-HC[®] Suppositories/ ANUSOL-HC[®] Cream

Before prescribing, please see full prescribing information. A Brief Summary follows:

Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in external and internal hemorrhoids, proctitis, papillitis, cryptitis, and fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol[®] Suppositories or Ointment.

CONTRAINDICATIONS

Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

WARNINGS

The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

PRECAUTIONS

General

Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.

Pregnancy

See "WARNINGS"

Pediatric Use

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

DOSE AND ADMINISTRATION

Anusol-HC Suppositories—Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

Store between 59°-86°F (15°-30°C)
1089G010

PERSONALS

R. W. BROWNING of Greenwood announces the association of FERNANDO LORA for the practice of general, thoracic and peripheral vascular surgery.

WALLACE CONERLY of UMC was guest lecturer for the Tri-State Respiratory Therapy Conference in Biloxi in August.

KENT A. DARSEY announces the opening of his practice at Collinsville Family Practice Clinic.

LARRY H. DAY of Hattiesburg announces the association of J. ROBERT COLTHARP, JR. at Ear, Nose, Throat and Facial Plastic Surgery, P.A., 5 Medical Boulevard.

JAMES C. GRIFFIN, JR. of Jackson recently received the Special Merit Award of the Mississippi Wildlife Federation.

CLYDE O. HAGOOD, JR. of Biloxi announces the association of WILLIAM P. KENNERLY for the practice of general and vascular surgery.

ARCHIE HOWARD announces the opening of his office for the practice of family medicine at 101 West 2nd Avenue, Morton.

RICHARD HUTCHISON of UMC was an instructor for a seminar on ECG interpretation and arrhythmia management in Hilton Head, SC.

MICHAEL E. JABALEY of Jackson recently attended a joint meeting of the American and British Societies for Surgery of the Hand, and lectured on "Technical Aspects of Nerve Repair."

SAMUEL B. JOHNSON of UMC recently attended an advisory board meeting at the Human Services Agency in Washington.

EDMUND MILLER, JR. announces the opening of his office for the practice of internal medicine at 217 West Broad Street in West Point.

W. LOUIS MOORE has associated with Columbus Pathology Laboratories, 306 Hospital Drive, Columbus.

NEELU L. NANDIWADA announces the opening of her practice of pediatrics at Doctors Clinic, 517 5th Avenue in Picayune.

JOE NORMAN of UMC was visiting lecturer at the University of Alabama Medical Center in Birmingham in August.

JAMES W. RAYNER of Oxford announces the association of SCOTT L. ROSEN in practice at 512 Van Buren Avenue.

WILLIAM E. RIECKEN, JR. of Jackson has been appointed to the position of State Epidemiologist for the Mississippi State Department of Health.

KELLY S. SEGARS, SR. of Iuka announces the association of ROGER B. MARLIN in the practice of family medicine at 1507 West Quitman Street.

STONEY WILLIAMSON of Harriesburg announces the association of KENNETH J. HAYLES in practice at the Hattiesburg Eye Clinic.

RALPH SNEED of Jackson announces the association of WILLIAM F. SNEED in practice at 916 North State St.

CHARLES M. WEBBER announces the association of WILLIAM P. HOWARD in practice at the Family Medical Center of Madison.

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When mild
to moderate pain
is a side effect
of "Fitness"

RUFEN[®]
(ibuprofen)

measures up...
at a reasonable
cost!

**A Single-Entity Pain Reliever
As-Good-As or Better-Than Codeine
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"...particularly effective in soft tissue disorders including sports injuries,"¹ Rufen stops pain at the site of injury and inflammation, not at the level of central perception. There is no dulled sensorium, no special need for warnings about driving or cautions about use of machinery. Your patient gets fast, effective pain relief...potent anti-inflammatory action...excellent tolerance...*plus* the exceptional economy that only Rufen offers. Next time one of your patients asks for pain relief, let Rufen show you how it measures up.



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Pioneers in medicine for the family

See next page for brief summary of prescribing information.

Measure RUFEN[®] (ibuprofen) against "standard" mild to moderate pain

Dental pain and episiotomy pain are predictable, reproducible "standards" that make possible objective comparisons of effectiveness of different analgesic agents.

- Measured against 15, 30 and 60 mg doses of codeine phosphate in a double-blind study of 287 patients, 400-mg doses of ibuprofen proved "significantly better than codeine on almost all pain intensity, degree of relief and duration of analgesia parameters."²
- Measured against a propoxyphene-acetaminophen combination for pain relief after 3rd molar extractions, ibuprofen proved equally effective and caused fewer side effects. Ibuprofen was associated with faster recovery, evidenced by more rapid reduction of trismus and return to normal function.³
- Measured against post-episiotomy pain in 30 patients, "ibuprofen was effective in treating the swelling as well as pain...during the first and worst days. Therefore, it is not only the analgesic but also the anti-inflammatory effect of ibuprofen that are the beneficial factors..."⁴



Measure RUFEN[®] (ibuprofen) against any mild to moderate pain

RUFEN	Acetaminophen + codeine combinations
• single-entity, peripheral-acting analgesia	• combined drugs act partly through central opioid pathways
• powerful treatment of both pain and inflammation	• virtually no treatment of the inflammatory component
• better tolerated than aspirin	• combined side effects of two drugs—warning required about driving or operating machinery; possible respiratory depression with alcohol, tranquilizers, other common medications
• no narcotic risk, red tape, records	• narcotic precautions required
• matchless economy in a modern NSAID	

References:

1. Hart FD, Huskisson EC, Ansell BM in Hart FD (editor): Drug Treatment of the Rheumatic Diseases. 2nd Ed, Adis Press, Balgowlah, Australia, 1982, p. 30.
2. Rondeau PL, Yeung E, Nelson P: Canad Dent Assoc J 46:433-439, 1980.
3. Selwyn P and Giles AD: Br Jrl of Clin Practice, Supplement 6, Safe and effective analgesia following dental surgery: A comparison of brufen and distalgesc. Pg 87-90, 1980.
4. Taina E: Curr Med Res Opinion, 7:423-428, 1981.



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And Rufen[®] Measures Up Best

RUFEN[®] (ibuprofen) Tablets

INDICATIONS AND USAGE: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in the long-term management of these diseases. Safety and effectiveness have not been established for Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain. Treatment of primary dysmenorrhea.

CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angio-edema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see WARNINGS).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally, however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: Coumarin-type anticoagulants. The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin. Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS: Incidence greater than 1%. **Gastrointestinal:** The most frequent adverse reaction is gastrointestinal (4 to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1% in 100. Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome and alopecia. **Special Senses:** hearing loss, amblyopia (blurred and/or diminished vision, scotomata and/or changes in color vision) [see PRECAUTIONS]. **Hematologic:** neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura eosinophilia, decreases in hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Allergic:** syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasms (see CONTRAINDICATIONS). **Renal:** acute renal failure in patients with preexisting significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria. **Miscellaneous:** dry eyes and mouth, gingival ulcers, rhinitis.

Causal relationship unknown. Gastrointestinal: pancreatitis. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri. **Dermatologic:** toxic epidermal necrolysis, photoallergic skin reactions. **Special Senses:** conjunctivitis, diplopia, optic neuritis. **Hematologic:** bleeding episodes. **Allergic:** serum sickness, lupus erythematosus syndrome, Henoch-Schönlein vasculitis. **Endocrine:** gynecomastia, hypoglycemia. **Cardiovascular:** arrhythmias (sinus tachycardia, bradycardia, and palpitations). **Renal:** renal papillary necrosis.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

DOSAGE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flareups of chronic disease: Suggested dosage 400 mg t.i.d. or q.i.d.

Dysmenorrhea: 400 mg every 4 hours as necessary.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for the relief of pain. Do not exceed 2,400 mg per day.

CAUTION: Federal law prohibits dispensing without prescription.

NEW MEMBERS

BATMAN, ANITA W., Pontotoc. Born Elmhurst, IL, July 6, 1941; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned and family medicine residency, University Medical Center, Jackson, MS, 1977-80; elected by Northeast Mississippi Medical Society.

FORD, VICTOR J., III, Jackson. Born Denver, CO, April 12, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned and ophthalmology residency, University Medical Center, Jackson, MS, 1977-81; glaucoma fellowship, LSU Eye Center, New Orleans, 1981-82; elected by Central Medical Society.

MERLOS, JOSE RICARDO, Pascagoula. Born El Salvador, Central America, May 1, 1945; M.D., University of El Salvador School of Medicine, 1974; interned National Medical Center, El Salvador one year; anesthesiology residency, Medical College of Wisconsin, 1975-78; anesthesiology fellowship,

same, 1978-79; elected by Singing River Medical Society.

WILLIAMS, STEVEN C., McComb. Born Memphis, TN, Feb. 8, 1952; M.D., University of Tennessee College of Medicine, Memphis, 1977; interned University of Tennessee, Memphis, one year; general surgery residency, University of Tennessee, Knoxville, 1977-81; vascular surgery fellowship, same, 1981-82; elected by South Central Medical Society.

DEATHS

WILSON, JOHN D., Columbus. Born Memphis, TN, Oct. 11, 1947; M.D., University of Tennessee College of Medicine, Memphis, 1972; interned University Hospital, Knoxville, TN, one year; surgery and neurosurgery residency, Baptist Memorial Hospital, Memphis, 1974-79; died Aug. 20, 1982, age 35.

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MEDICAL ORGANIZATION

Observers See Indicators of Medical Malpractice Crisis

A medical malpractice jury verdict rendered in June has set a Mississippi record. A Circuit Court jury returned a verdict awarding \$2 million in damages to a Tupelo man who allegedly suffered complications following a December 1977 bilateral carotid angiogram.

Mississippi observers see that case and several other factors as indicators of a trend toward a new medical malpractice crisis.

"Crisis of affordability" is the phrase used by Dr. C. G. Sutherland, medical director of the MSMA-sponsored captive, Medical Assurance Company of Mississippi, Inc., to describe the situation in a special article elsewhere in this issue.

The situation has resulted in an effort to seek relief through legislation. Portions of MSMA's legislative proposals for the upcoming 1983 Regular Session of the Mississippi Legislature may include some of the following recommendations: (1) to shorten the statute of limitations on actions brought by minors, (2) to require hospitals to carry liability insurance, (3) to allow physicians to release medical records at the time a claim is made rather than when suit is filed, (4) to require that an expert evaluate a claim prior to the filing of suit, (5) to make admissible in court evidence of payments the claimant received from collateral sources, and (6) to prohibit the use of a monetary figure in the *ad damnum* clause.

The increase in claims in the past decade is an indicator of the medical malpractice situation in Mississippi. In 1972 there were only 18 claims pending against health care providers in Mississippi; thus far in 1982 there are over 400 medical malpractice claims against individual Mississippi physicians.

Another indicator of the situation is expenditures by various carriers. As of September, expenditures by the various Mississippi carriers, in claims and expenses, have exceeded \$3 million. And the carriers currently are carrying well over \$20 million in contingency liability reserves for pending cases.

The resulting increase in premiums, borne by physicians and patients alike, has not been insignificant. Over the past three years, for example, the cumulative compounded rate increase has amounted

to 170% for St. Paul and 120% for Medical Assurance Company.

The legislative effort is not the only attempt to bring increasing medical malpractice costs under control, according to Medical Assurance spokesmen, who point to the organization's effort to meet the need for (1) continuing physician education in the field of legal medicine and (2) a public information campaign regarding the increasing costs and the effects on both the physician and the patient.

PADD Receives Growing Support

Physicians Against Drunk Drivers (PADD), MSMA's committee working toward eliminating drunken drivers from the roads and highways of the state, has been meeting regularly and appears to be gaining support from other groups interested in the problem.

At its most recent meeting the committee invited representatives of the legal profession, who expressed a great deal of interest in supporting some reforms in the present method of handling DUI cases. Stating a desire to be an ongoing part of the effort spearheaded by PADD, representatives of the Mississippi State Bar Association extended an invitation for a PADD representative to meet with the Board of Bar Commissioners. The Bar was the second such group to request input at their board meeting, the first being the Justice Court Judge's Association.

Since the formation of the MSMA committee, several other groups have begun to take a more active role in preparing plans of action for the upcoming session of the Mississippi Legislature. Additionally, at press time, the national director of RID (Remove Intoxicated Drivers) was scheduled to meet with the committee.

Future plans include not only legislative action but also the preparation of a 15-25 minute slide presentation which will be made available to interested groups and which can be presented by physicians in their communities.

Mark Russell to Entertain During 115th Annual Session



Mark Russell, noted political satirist, will be the feature entertainment at the MSMA/MSMA Auxiliary banquet on Friday, May 13, 1983, in Biloxi. The announcement of the entertainer's appearance during the 115th Annual Session was made during the July 29 meeting of the Council on Scientific Assembly.

For 20 years resident comedian at the Shoreham Hotel in Washington, DC, Russell has specialized in a topical humor which "makes people, politics and politicians seem even more absurd than usual."

Typical of his satire is a remark during one performance at the Shoreham, when he pointed to the three-piece bank behind him and declared, "This is what the National Symphony Orchestra will look like after the budget cuts." He directed his humor at fiscal problems of the states with the remark that during the governors' conference in Atlantic City, "I saw one governor standing next to the roulette wheel, betting a block grant on 11 red." And demonstrating what he claims is his main charitable work — cheering up those who are out of power in Washington — is his remark, "Do you get the idea that Richard Nixon is Secretary of State and they don't have the heart to tell us?"

Russell has taken his "roasting" of Washington to television, where he has appeared as a guest on many major television shows, as well as entertaining millions of viewers with his own comedy specials on the Public Broadcasting System. His syndicated column appears in 100 newspapers, and he is the author of a book, *Presenting Mark Russell*. He has recorded four albums, "Assault With a Deadly Peanut," "The Wild, Weird, Wired World of Watergate," "The Face on the Senate Floor," and "Up the Poto-mac without a Canoe."

Physicians Affected by Changes In Workmen's Compensation Rules

Changes made in the Workmen's Compensation Law during the 1982 session of the Mississippi Legislature and rules promulgated subsequently by the Workmen's Compensation Commission now require a few adjustments by physicians who treat claimants.

Because some of the forms have been revised, most notably the B-9 and B-27 forms, old forms will no longer be accepted by the Commission after December 1, 1982.

The second change directly affecting physicians' offices is that in addition to sending copies of medical reports to the employer and/or carrier as has been the practice in the past, the physician is now required to also send a copy of such reports to the Commission.

The third requirement is not new but has not necessarily been enforced in the past. The rule requiring a medical report to be filed within 20 days of the initial visit will now be enforced. If medical reports are not received within the 20-day period, the Commission may deny payment to the physicians.

Physicians are urged to take note of the changes and notify their office personnel accordingly.

115th Annual Session May 11-15, 1983 *Preliminary Program*

Wednesday, May 11

Golf Tournament
President's Reception

Thursday, May 12

House of Delegates
Reference Committees
Miss. Foundation for Medical Care
Medical Alumni Reunions

Friday, May 13

Section on Family Practice
Section on Surgery/American College of Surgeons
Section on Medicine
Section on Ob-Gyn
Section on Pediatrics
Section on Preventive Medicine
MSMA Banquet (Mark Russell)

Saturday, May 14

Medical Assurance Company of Miss.
Section on EENT
Section on Anesthesiology
Section on Pathology
Section on Psychiatry
Section on Radiology
Section on Urology
Section on Dermatology
MSMA Auxiliary General Meeting
Tennis Tournament
MMPAC Campaign Reception

Sunday, May 15

House of Delegates

Auxiliary Announces Fall Workshop Agenda

"Images" is the theme of the 15th annual fall workshop of the MSMA Auxiliary, scheduled for October 26 at the Jackson Regency Hotel.

According to workshop coordinator Mrs. Stanley Hartness, "Images seeks to furnish information concerning community programs and project ideas for both large and small membership auxiliaries, while individual members gain new insight into self improvement. An outstanding group of leaders promises to make Images an exceptional learning experience."

Program participants include Mrs. Jim Milam, director of DREAM, Drug Research and Education Association of Mississippi, Inc.; Dr. Jim Robbins, Greenwood urologist and member of MSMA's Committee on Drunken Drivers; Dr. Patrick Tarpy, McComb pediatrician and Mississippi coordinator of "The First Ride — A Safe Ride"; Mrs. Carolyn Evans of the Governor's Highway Safety Program; Mr. Bucky Murphy, MSMA legal counsel; Mrs. Sue Hathorn, director of SCAN (Suspected Child Abuse and Neglect) America of Mississippi, Inc.; Mr. Ronnie Tew, Columbus bank president; and Mrs. John Jackson, member of the AMA Auxiliary Health Projects Committee.

Physicians and spouses are invited to attend the sessions. The registration fee of \$12.50 includes continental breakfast and lunch. For more information, please contact Mrs. Stanley Hartness, P.O. Box 569, Kosciusko, MS 39090; telephone (601) 289-6497.

IMAGES MSMA Auxiliary Fall Workshop

October 26, 1982
Jackson Regency Hotel

9:00- 9:30 Hospitality
9:30-10:15 Business Meeting

WORKSHOPS

10:20-11:50 "DREAM"
Mrs. Jim Milam
10:20-11:20 "I Don't Want to Get Involved in Politics!"
Bucky Murphy
"The First Ride — A Safe Ride"
Dr. Patrick Tarpy
Mrs. Carolyn Evans
"Why Health Education in Your School?"
Mrs. John Jackson
11:25-12:25 "I Can Drive When I Drink"
Dr. Jim Robbins
"Somewhere A Child Is Crying"
Mrs. Sue Hathorn
"All in Good Time"
Ronnie Tew
12:30- 1:30 Lunch
1:30- 2:30 "Coalitions: Getting Together to Get Things Done"
Mrs. John Jackson
2:30 Tour of Manship House

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one dose against pinworm and roundworm—in both children and adults—Antiminth is easy-to-administer and easy-to-take.

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In some parts of the world, large populations are afflicted with helminthic infections. Physicians in endemic areas have become experts on parasitic diseases—and have come to rely on Antiminth for the rapid cure of infestations. Antiminth is recommended as an agent of first choice for pinworm and roundworm by leading medical authorities.³

Warnings

Usage in Pregnancy Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions

Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions

The most frequently encountered adverse reactions are related to the gastrointestinal system. Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration

Children and Adults Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

References 1. Pitts NE, Migliardi JR: *Clinical Pediatrics* 13:87, 1974. 2. Modell W: *Drugs of Choice* 1980-1981. C. V. Mosby Co., St. Louis, 1980, p. 362. 3. Goodman LS, Gilman A: *The Pharmacologic Basis of Therapeutics*, 6th edition, MacMillan Publishing Co., Inc., New York, 1980, p. 1032.



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UMC Names New Director Of Minority Student Affairs

Dr. Billy Ray Ballard is new director of minority student affairs at the University of Mississippi Medical Center in Jackson. A dentist and a physician, Dr. Ballard joined the faculty as an associate professor of pathology in the School of Medicine and an associate professor of oral pathology and oral radiology in the School of Dentistry.

In announcing Dr. Ballard's appointment, Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean, said, "We are pleased to have a health professional of Dr. Ballard's caliber and experience assume this important position."

The Office of Minority Student Affairs was established at the Medical Center in 1973 to work with and encourage minority students in preparing for health careers.

Prior to his UMC appointment, Dr. Ballard was an associate professor of pathology at Meharry Medical College in Nashville and chairman of the department of oral pathology at the Meharry School of Dentistry. Since 1976, Dr. Ballard also had been a

visiting professor of oral pathology in the dental school at the State University of New York at Buffalo.

A prime goal for the program he heads is increasing minority student enrollment in all areas — medicine, nursing, health related professions, dentistry and the basic sciences. "The health sciences offer excellent opportunities and we hope to help each student make the best career choice."

A native of Arcadia, Louisiana, Dr. Ballard earned the B.S. at Southern University, the D.D.S. at Meharry and the M.D. at Meharry Medical College.

Dr. Ballard was a resident in pathology at George W. Hubbard Hospital of Meharry Medical College from 1965-1967 and at Roswell Park Memorial Institute from 1967-1970. He took a postdoctoral fellowship in the Department of Oral Pathology at the State University of New York.

Faculty Appointments At UMC

The University of Mississippi Medical Center has added three to the School of Medicine and centerwide faculties.

Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean, announced their appointment following approval by the Board of Trustees, State Institutions of Higher Learning.

On the centerwide faculty, Dr. Douglas Frank Ward and Dr. John David Dignam were named assistant professors of biochemistry. Dr. David Graham Schlundt was named an instructor in medicine in the School of Medicine.

Dr. Dignam, a B.S. graduate of the University of Houston, earned the Ph.D. at the University of Texas at Houston. Prior to joining the UMC faculty he took postdoctoral fellowships in biochemistry at the University of Connecticut Health Center and in biological chemistry at the University of Washington School of Medicine.

A B.A. and M.A. graduate of Oxford University, Dr. Ward earned the Ph.D. at the University of Edinburgh. He had been a postdoctoral fellow at the National Cancer Institute, National Institutes of Health since 1979.

Dr. Schlundt earned the A.B. at Indiana University, the M.S. at the University of Wisconsin and the Ph.D. at Indiana University. He had been a resident in psychology at UMC since 1981.

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Boswell Lecturer Announced

Dr. Lincoln J. Bynum, assistant director of pulmonary medicine at the Presbyterian Hospital of Dallas, will present the 1982 Boswell Lecture during the Mississippi Thoracic Society annual session November 2 at the University of Mississippi Medical Center in Jackson.

Dr. Bynum's topic is non-thrombolytic therapy. He will speak November 2 at 12 noon at UMC.

The Boswell lectureship, established in 1971, honors the late Dr. Henry Boswell who served as the first superintendent of the Mississippi State Sanatorium.

Dr. A. Jerald Jackson of Hattiesburg is seminar coordinator. On the program are Dr. Robert P. Henderson of Jackson, Dr. Gvrk Sharma of the Veterans Administration Medical Center in West Roxbury, Mass., and Dr. Seshadri Raju, UMC professor of surgery.

Sponsors are the Mississippi Lung Association, the Mississippi Thoracic Society, the UMC School of Medicine Department of Medicine Pulmonary Division and the Medical Center Division of Continuing Health Professional Education.

Course fee is \$10. For more information, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, Mississippi 39216. Phone: (601) 987-4914.

Forrest General Hospital Hosts Medical Emergencies Symposium

"Current Concepts in the Management of Medical Emergencies" is the theme of a symposium scheduled for November 4, 1982, at Forrest General Hospital. The meeting is co-sponsored by Forrest General Hospital and Hattiesburg Clinic, P.A.

The course is designed to provide primary care physicians with a review and update on the initial evaluation and management of medical emergencies which occur commonly in medical practice. Topics to be covered include: initial management of myocardial infarction and other cardiac emergencies; hypertensive crisis; acute respiratory failure; fluid electrolyte and acid base derangements; acute G.I. bleeding; and initial evaluation and specifics in management of shock.

For more information contact Dr. Douglas F. Thomas, program chairman, Hattiesburg Clinic P.A., 415 South 28th Avenue, Hattiesburg, MS 39401.

Review A Book

The following books have been received. Members of MSMA interested in reviewing any of these volumes should address their requests to Editor, JOURNAL MSMA, P.O. Box 5229, Jackson, MS 39216. After submitting to the JOURNAL a review for publication, you may keep the books for your personal libraries.

Physician's Handbook: Twentieth Edition. Los Altos: Lange Medical Publications, 1982. \$12.00.

Current Medical Diagnosis & Treatment. Edited by Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. Los Altos: Lange Medical Publications, 1982. \$26.00.

Review of Medical Microbiology: Fifteenth Edition. Los Altos: Lange Medical Publications, 1982. \$17.00.

Current Pediatric Diagnosis & Treatment: Seventh Edition. Los Altos: Lange Medical Publication, 1982. \$26.00.

Basic & Clinical Immunology: Fourth Edition. Los Altos: Lange Medical Publications, 1982. \$22.00.

Current Obstetric & Gynecologic Diagnosis & Treatment: Fourth Edition. Edited by Ralph C. Benson, M.D. Los Altos: Lange Medical Publications, 1982. \$25.00.

Principles of Clinical Electrocardiography: Eleventh Edition. Edited by M. J. Goldman, M.D. Los Altos: Lange Medical Publications, 1982. \$15.00.

Gastroenterology Seminar Set for October 30

Magnolia Hospital and Alcorn County Medical Club are co-sponsors of a seminar on gastroenterology set for October 30 at Pickwick Landing State Park Inn.

Seminar topics include: pseudomembranous colitis; viral hepatitis; gallstones; non-ulcer dyspepsia; differential diagnosis of jaundice; management of G.I. bleeding; screening for colon cancer; new therapy of peptic ulcer disease; and gallbladder scans.

For more information contact Mrs. Jane Kaup, CME coordinator, Magnolia Hospital, Alcorn Drive, Corinth, MS 38854.

PLACEMENT SERVICE

Physicians Wanted

FAMILY PRACTITIONER wanted to locate in East Central Mississippi community, population 1,000 with trade area of 10,000. Clinic will be provided if desired. Contact Sandersville Health Care Services, Inc., Drawer C, Sandersville, MS 39477.

FAMILY PRACTITIONERS. Excellent private practice opportunity, well equipped 30-bed hospital in operation less than two years. Office space available in renovated clinic, 100-bed nursing home, nice community, good schools and recreational facilities, located 30 miles east of Jackson. Call (601) 732-6252 or write A. B. Farris, Jr., Mayor, P. O. Drawer 338, Morton, MS 39117.

NOTICE

INTERNS, RESIDENTS, ANY PHYSICIAN LICENSED TO PRACTICE MEDICINE IN MISSISSIPPI

Positions for part-time medical consultants are now available at the Disability Determination Services of Mississippi. The pay and hours are good. Interns and residents wanting to interrupt their training programs for a year or more are welcome to apply. If interested, call 922-6811, ext. 2277 (Dr. John Barr) or ext. 2000 (Mr. John Cook).

Situations Wanted

HEMATOLOGIST-ONCOLOGIST seeks associate or solo practice. Contact Thomas Twele, M.D., 272 Shadow Mountain, El Paso, TX 79912.

PHYSICIAN completing pathology residency in September 1982 seeks location with pathology group with emphasis on surgical pathology. Graduate of University of Tennessee School of Medicine. Contact Dr. William D. Crump, 1027-B Beacon Parkway East, Birmingham, AL 35209.

FAMILY PRACTICE resident seeks practice location in July 1983. Contact John D. Sites, M.D., 2002 Philip Dr., Muncie, IN 47302.

ANESTHESIOLOGIST seeks to relocate in state in solo, group or institutional practice. Contact M. T. Olivo, Jr., M.D., Box 794, Oxford, MS 38655.

BOARD ELIGIBLE PATHOLOGIST seeks practice opportunity. Graduate of University of Mississippi School of Medicine; residencies, UMC. Contact Marianna G. Pardue, M.D., 315 Cedarwood, Jackson, MS. 39212.

BOARD CERTIFIED FAMILY PRACTITIONER seeks practice location. Currently completing military obligation and available 7/82. Contact John E. Bailes, Jr., M.D., 5405 Hackney Circle, Bossier City, LA 71111.

OCCUPATIONAL HEALTH physician seeks position in industry or similar position. M.D. from University of Miami, 1962. Residency in internal medicine at Erlanger Hospital, Chattanooga, and at UMC, Jackson. Contact: Gary LeBow, M.D., 202 Vail Avenue, #218, Homewood, AL 35209; (205) 942-0993.

SURGEON seeks location with established group in small city. Currently service as chief surgical resident at Ochsner Foundation Hospital. Available July 1983. Contact Thomas C. Kelly, M.D., 1516 Jefferson Highway, New Orleans, LA 70121.

PATHOLOGIST-ONCOLOGIST seeks practice location. Frank P. Urso, M.D., P. O. Box 1149, Akron, OH 44301.

CLASSIFIED

GENERAL SURGEON AND INTERNIST NEEDED. Rural, well-equipped, 50-bed hospital in Northeast Mississippi. Recently renovated. Offers fantastic opportunity for board certified or board eligible physician. Call or write Carson Wood, Administrator, Community Hospital of Calhoun County (601) 983-4321, P.O. Box 128, Pittsboro, MS 38951. (Other locations may be available.) A U.S. Health Corporation hospital.

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IN CONCLUSION

The FDA's approval process for new drugs will be streamlined, HHS Secretary Richard Schweiker announced in a speech before the National Pharmaceutical Council. He said the FDA would develop guidelines to assist the sponsors of a new drug to develop research protocols, reduce the amount of material needed in an application, allow approval of drugs based on foreign data, and avoid unnecessary delays in the approval process. The AMA had not reviewed the proposed changes in detail, but applauded the intent.

Medicare coverage for optometrists' services in the treatment of aphakia has been opposed by the AMA. In a letter to the Health Care Financing Administration, the AMA said that a proposal to expand coverage to include optometrists' services would not improve the quality of care but would incur significant additional expenses to the program. The AMA pointed out that the patient generally receives treatment for the condition from the operating physician, and said an optometrist is unqualified to treat post-operative complications that may occur.

While the proportion of heavy and problem drinkers is less among the elderly than any other adult age group, there are several elderly subgroups that seem to be at high risk for development of alcoholism. Higher than average rates of problem drinking are reported among widowers and singles of both sexes, for instance. More information on alcohol use and problems among the elderly is offered in a free brochure, In Brief: Alcohol and the Elderly, available from National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852.

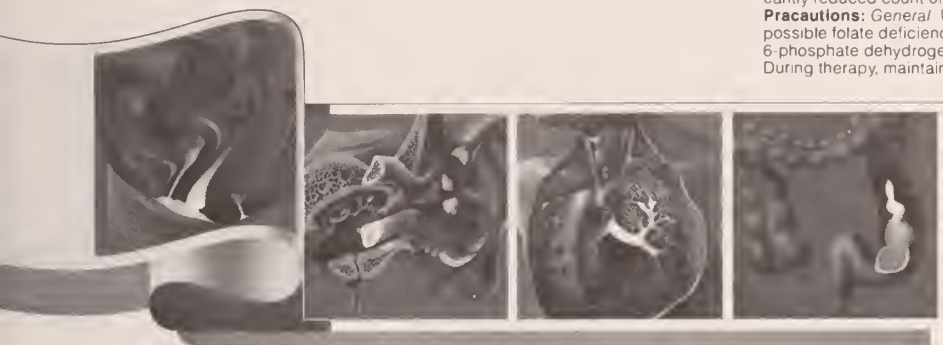
At least some of the changes commonly attributed to aging are really caused by inactivity and as such are subject to correction, according to a physician who advocates exercise as a way to ward off some of the age-related disabilities. In an article in the Sept. 10 issue of JAMA, the physician compares the bodily results of physical inactivity in younger people to the decreased capacity of older people. He maintains that no drug holds as much promise for sustained health as a lifetime program of physical exercise.

A selective directory of information resources for the visually impaired is included in the Sept. 10 issue of JAMA. Almost 11 million people in the U.S. suffer from some degree of decreased vision that cannot be restored to normal by corrective lenses or surgery, according to the author. He reports that in 1978, although the number of persons with some usable vision (low vision) far outnumbered those who were blind, there was only one low-vision service organization for every five such organizations for the blind.

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Dosage: Not recommended for infants less than two months of age.
URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

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Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.
For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.
For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.
For antitoxin due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
Also for the treatment of documented *Pneumocystis carinii* pneumonia.
Contraindications: Hypersensitivity to trimethoprim or sulfonamides, patients with documented megaloblastic anemia due to folate deficiency, pregnancy at term, nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus, infants less than 2 months of age.
Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.
Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.
Pregnancy: Teratogenic Effects. Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folate metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.
Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea, pseudomembranous colitis and pancreatitis. CNS reactions:

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1. Rubin RH, Swartz MN: *N Engl J Med* 303:426-432, Aug 21, 1980 2. Data on file, Medical Department, Hoffmann-La Roche Inc.

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WARNINGS

CARDIAC FAILURE In congestive heart failure, inhibition with beta-blockade carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. In patients already receiving digitalis, propranolol may reduce the positive inotropic action of digitalis and may have an additive depressant effect on AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, in rare instances, cardiac failure has developed during propranolol therapy. At the first sign of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and observed closely a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol should be immediately withdrawn, b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Give special consideration to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Propranolol should be withdrawn slowly, since abrupt withdrawal may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta-blockade impairs the ability of the heart to respond to reflex stimuli. Except in pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery. In case of emergency surgery, the effects of propranolol can be reversed by administration of beta-receptor agonists such as isoproterenol or levaterenol, but such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), administer with caution, since propranolol may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta-receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA Propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia, especially in patients with tabile diabetes. A precipitous elevation of blood pressure may accompany hypoglycemic attacks.

USE IN PREGNANCY Safe use in human pregnancy not established. Embryotoxic effects have been seen in animals at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if propranolol is administered, since it may occasionally produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

Observe laboratory parameters at regular intervals. Use with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, arterial insufficiency usually of the Raynaud type, thrombocytopenic purpura. **Central Nervous System** lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. **Gastrointestinal** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. **Allergic** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. **Respiratory** bronchospasm. **Hematologic** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. **Miscellaneous** reversible alopecia. **Oculomucocutaneous** reactions involving the skin, serous membranes and conjunctivae reported for a beta-blocker (practolol) have not been conclusively associated with propranolol. **Clinical Laboratory Test Findings** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

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Reference: 1. Freis, E. D. Hypertension (Suppl. II) 3: 230 (Nov.-Dec.) 1981

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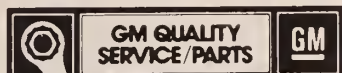
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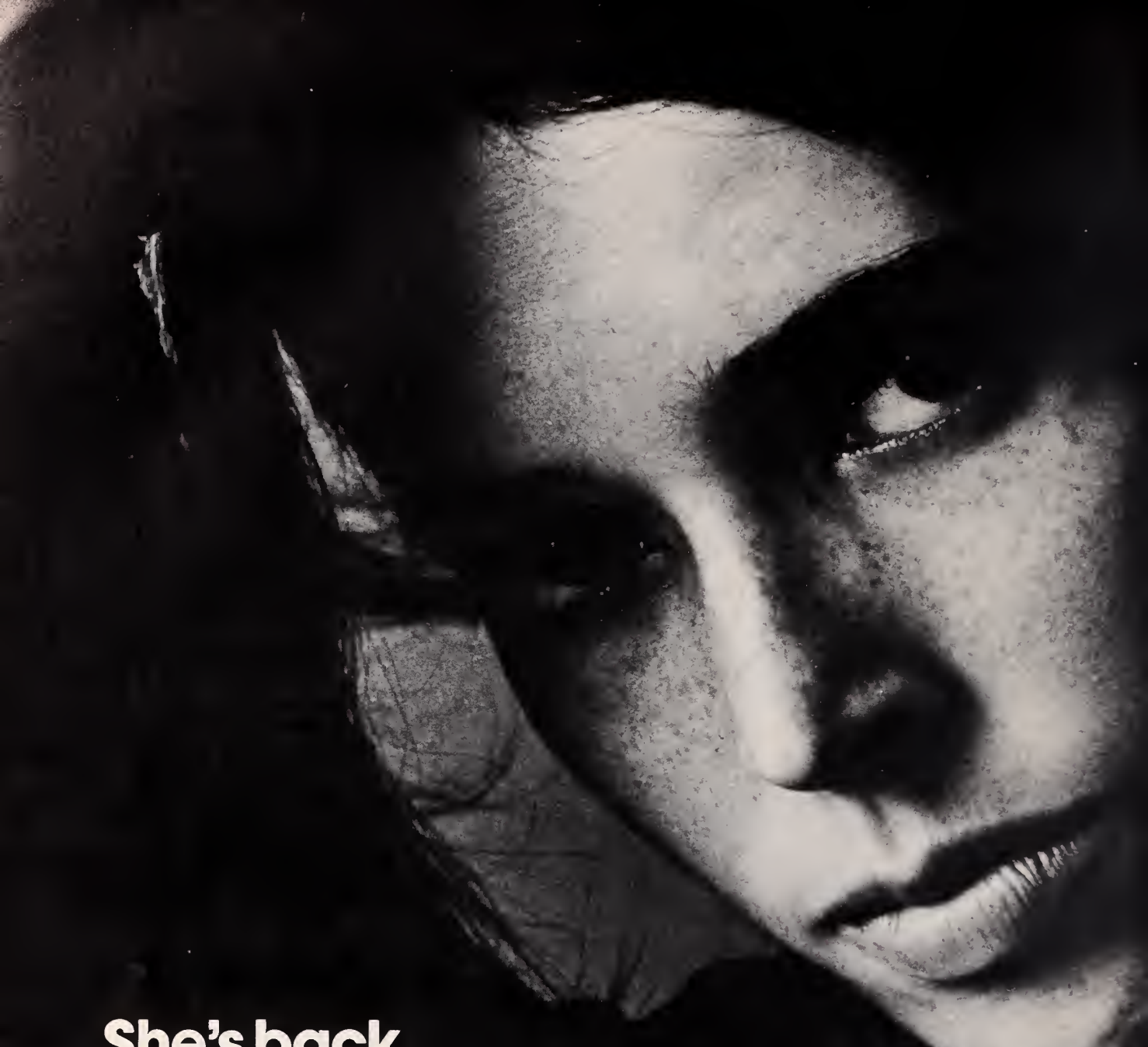
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Riverside is licensed by the Mississippi Commission on Hospital Care, and is fully accredited by the Joint Commission on Accreditation of Hospitals.

The medical staff includes a large number of psychiatrists in private practice in the Jackson area. A toll-free number, 1-800-962-2180, has been established at the hospital for referral service to physicians on the active medical staff.

Physicians who have patients who would benefit from the type of treatment approach offered by Riverside may obtain referral information by contacting the Director of Admissions.

Riverside Hospital

P.O. Box 4297, Jackson, Mississippi 39216

Telephone: (601) 939-9030

Incoming Mississippi WATS: 800-962-2180

NEWSLETTER

November 1982

Dear Doctor:

Competition for patients is increasing and is having a definite impact on medical practice in the United States, according to a survey of 1,000 physicians conducted by the AMA Group on Public and Federation Relations. Nearly three of four physicians said they believed that there is a current or impending surplus of physicians in certain specialty areas in their communities, with surgery heading the list.

An increasing number said there are too many physicians in their communities (41% this year compared to 33% in 1981). The public perception of the competition situation differs strongly, however. While only 6% of physicians believe that there are too few physicians in their communities, more than a third of the public continues to believe that there are too few physicians. And while 73% of the physicians believe that there is or will be a local surplus of physicians in certain specialties, there is almost no public support for the position that the medical profession may become oversupplied, according to the survey.

"Competition in Health Care - Present and Future" will be the theme of a seminar in Jackson on Nov. 19. Among speakers are Dr. Walter McClure of Minneapolis, a leading advocate of competition, and Dr. Harrison L. Rogers, Jr., speaker of the AMA House of Delegates. The seminar is co-sponsored by MSMA, Miss. Hospital Assn., and Miss. Assn. of Hospital Governing Boards.

The FDA published in September a proposed rule that would require that over the counter drugs which are systemically absorbed into the body contain a label warning pregnant or nursing women against the use of such drugs in the absence of professional advice. The FDA will grant exemptions from the warning requirement where it deems appropriate.

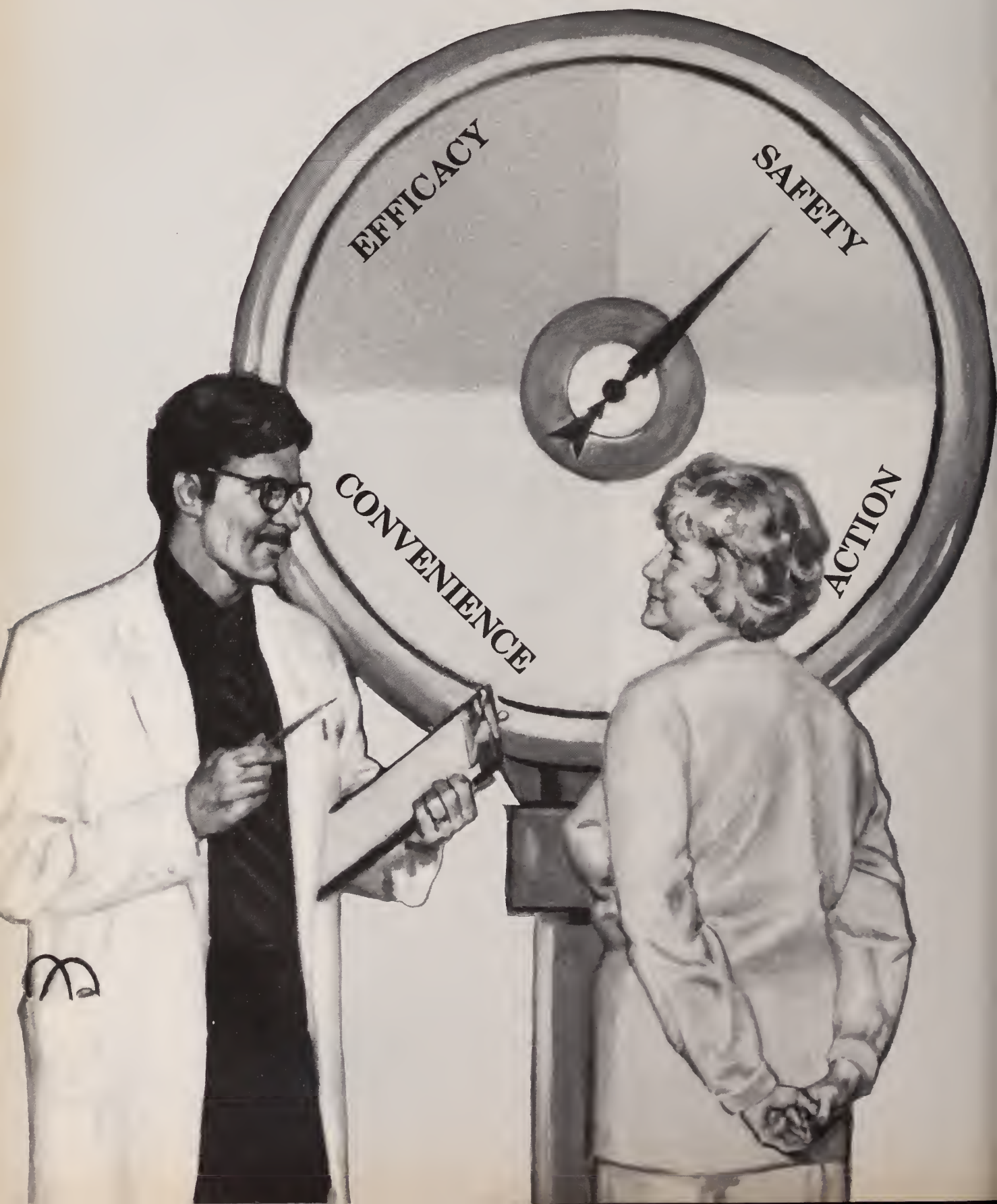
In another matter concerning OTC drugs, HHS Secretary Schweiker announced that the FDA would be issuing regulations requiring tamper-resistant packaging for OTC drugs. The announcement is in the wake of the Tylenol poisonings that killed seven persons in Chicago. Schweiker said his action was designed to head off numerous local requirements.

Sincerely,



Patsy Silver
Managing Editor

When your overweight patients seek your help with a weight reduction plan...



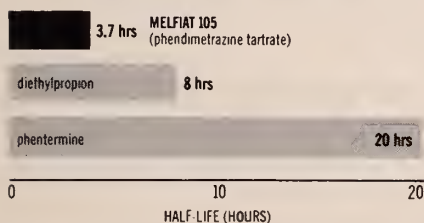
The benefits will outweigh the risks when you prescribe MELFIAT® 105

Because MELFIAT 105 effectively controls appetite. MELFIAT 105 (phendimetrazine tartrate), an effective anorexiant, provides the appetite control overweight patients often need to begin a successful program of weight reduction. And the positive results of initial short-term therapy with MELFIAT 105 can help motivate them to a lifelong commitment of weight control.

Because MELFIAT 105 has a 3.7 hour half-life and low abuse potential.

Therapeutic efficacy combined with a short half-life and minimal abuse potential make MELFIAT 105 the drug of choice in the treatment of exogenous obesity. Because MELFIAT 105 has a short half-life, it minimizes drug accumulation and helps to eliminate such effects as disturbed sleep patterns. And, because MELFIAT 105 has significantly lower abuse potential than the amphetamines,¹ there's less risk to your patients. According to a NIDA (National Institute on Drug Abuse) report, phendimetrazine appears to be the least abused anorexiant when compared to phentermine and diethylpropion.¹

Half-life comparison of MELFIAT 105 and other anorexiant²s



MELFIAT® 105 UNICELLES® C^{III}

(phendimetrazine tartrate)
Sustained-Release Capsules 105 mg

Because MELFIAT 105 is in a sustained-release capsule.

MELFIAT 105 provides your patients with continuous drug delivery for appetite control that lasts throughout the day and helps to eliminate compulsive snacking and overeating at meals. In addition, the sustained-release capsule form maintains more constant blood levels of MELFIAT 105...without peaks and valleys.

Because MELFIAT 105 offers convenient, once-a-day dosage.

MELFIAT 105 is available in a convenient capsule containing 105 mg. The simple morning dosage regimen is designed to encourage compliance, minimizing the chance of missed doses and assuring optimum therapeutic results.

Because MELFIAT 105 is from Reid-Provident Laboratories, Inc.

Reid-Provident has the highest standards of quality to assure that only the finest products reach you. An advisory board of research scientists, physicians, pharmacists, and other technical staff continually review existing products and new product proposals to make sure that the latest pharmaceutical technology is used in their design and manufacture. That's because Reid-Provident is committed to you and your patients.

For more information please write to Reid-Provident Laboratories, Inc.
640 Tenth Street, N.W.
Atlanta, Georgia 30318

References: 1. Sheu YS, Ferguson JA, Cooper JR: *Evaluation of the Abuse Liability of Diethylpropion, Phendimetrazine, and Phentermine*, unclassified document ADAMHA, HHS, Office of Medical and Professional Affairs, NIDA, 1980. 2. Douglas JG, Munro JF: The role of drugs in the treatment of obesity, *Drugs* 21:362-373, 1981.

MELFIAT® 105 UNICELLES® C

(phendimetrazine tartrate) 105 mg Sustained-Release Capsules

INDICATIONS AND USAGE: Melifat® 105 (phendimetrazine tartrate) is indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class (See CLINICAL PHARMACOLOGY) should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result).

WARNINGS: Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should be discontinued. Phendimetrazine tartrate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

Drug Dependence: Phendimetrazine tartrate is related chemically and pharmacologically to the amphetamines. Amphetamines and related stimulant drugs have been extensively abused, and the possibility of abuse of phendimetrazine tartrate should be kept in mind when evaluating the desirability of including a drug as part of a weight-reduction program. Abuse of amphetamines and related drugs may be associated with intense psychological dependence and severe social dysfunction. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high-dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG, manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia.

USAGE IN PREGNANCY: The safety of phendimetrazine tartrate in pregnancy and lactation has not been established. Therefore, phendimetrazine tartrate should not be taken by women who are or may become pregnant.

USAGE IN CHILDREN: Phendimetrazine tartrate is not recommended for use in children under 12 years of age.

PRECAUTION: Caution is to be exercised in prescribing phendimetrazine tartrate for patients with even mild hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of phendimetrazine tartrate and the concomitant dietary regimen. Phendimetrazine tartrate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage.

ADVERSE REACTIONS: Cardiovascular: Palpitation, tachycardia, elevation of blood pressure.

Central Nervous System: Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache; rarely psychotic episodes at recommended doses.

Gastrointestinal: Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances.

Allergic: Urticaria.

Endocrine: Impotence, changes in libido.

OVERDOSAGE: Manifestations of acute overdosage with phendimetrazine tartrate include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states.

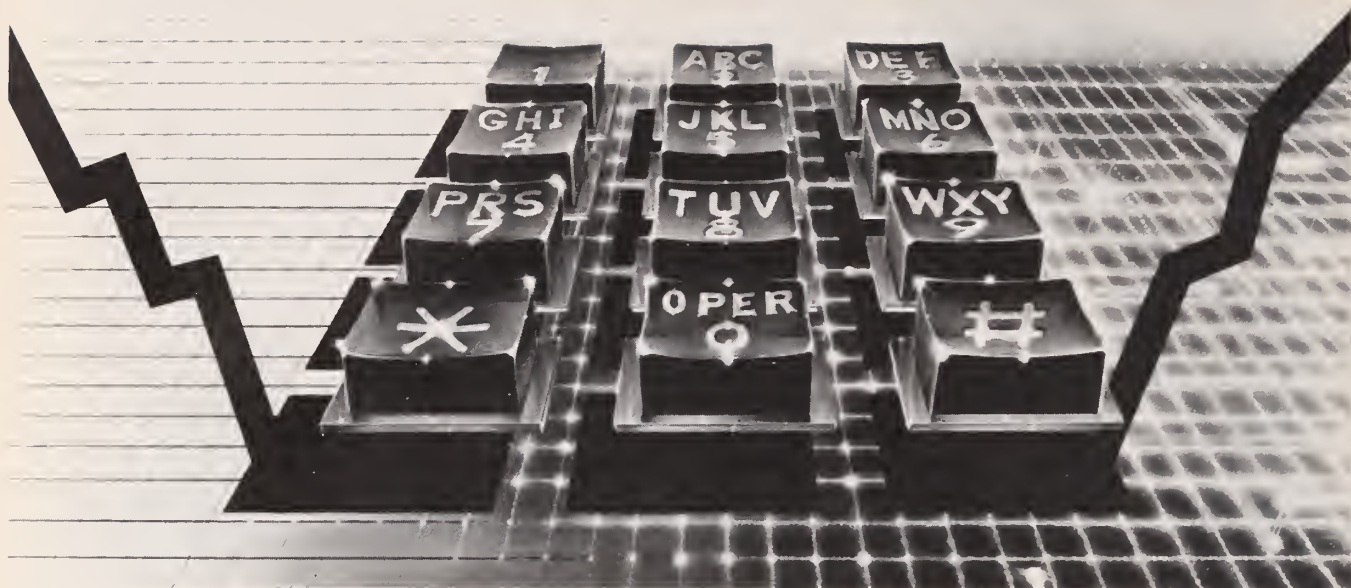
Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma. Management of acute phendimetrazine tartrate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Acidification of the urine increases phendimetrazine tartrate excretion. Intravenous phentolamine (Regitine) has been suggested for possible acute, severe hypertension, if this complicates phendimetrazine tartrate overdosage.

DOSE AND ADMINISTRATION: Since Melifat® 105 (phendimetrazine tartrate) 105 mg is a sustained-release dosage form, limit to one sustained-release capsule in the morning. Melifat® 105 (phendimetrazine tartrate) is not recommended for use in children under 12 years of age.

HOW SUPPLIED: Each orange and clear sustained-release capsule contains 105 mg phendimetrazine tartrate in bottles of 100.

CAUTION: Federal law prohibits dispensing without prescription.





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DATELINE

Committee Recommends MSMA Reorganization

Jackson, MS - MSMA's Committee to Study Reorganization will recommend to the Board of Trustees and House of Delegates the development of a seven district - ten member Board with the president, president-elect and immediate past president as voting members and with the addition of one at-large trustee. Board representation will be based on membership totals in each district, with the new District 4 having three trustees and each of the other new districts having one trustee.

MDs Should Advise on Fetal Alcohol Damage

Washington, DC - Physicians should advise pregnant women the safest course to protect the fetus from damage due to alcohol is to abstain from drinking, witnesses for the AMA told Congress. LeClair Bissell, M.D., a member of the AMA Panel on Alcoholism, told a subcommittee on alcohol and drug abuse that "research clearly indicates that excessive use of alcohol during pregnancy can negatively affect the fetus," and said some research suggests even moderate use may be damaging.

AMA To Fight Rx Drug Abuse

Chicago, IL The AMA is mounting a major initiative to combat prescription drug abuse. A steering committee will develop a model system for states to use in analyzing data to pinpoint MDs who overprescribe controlled drugs. The model will be available next year through state medical societies. Also, there are plans for a series of state and regional conferences on the misuse, abuse, and diversion of prescription drugs.

More Action Against Drunk Drivers

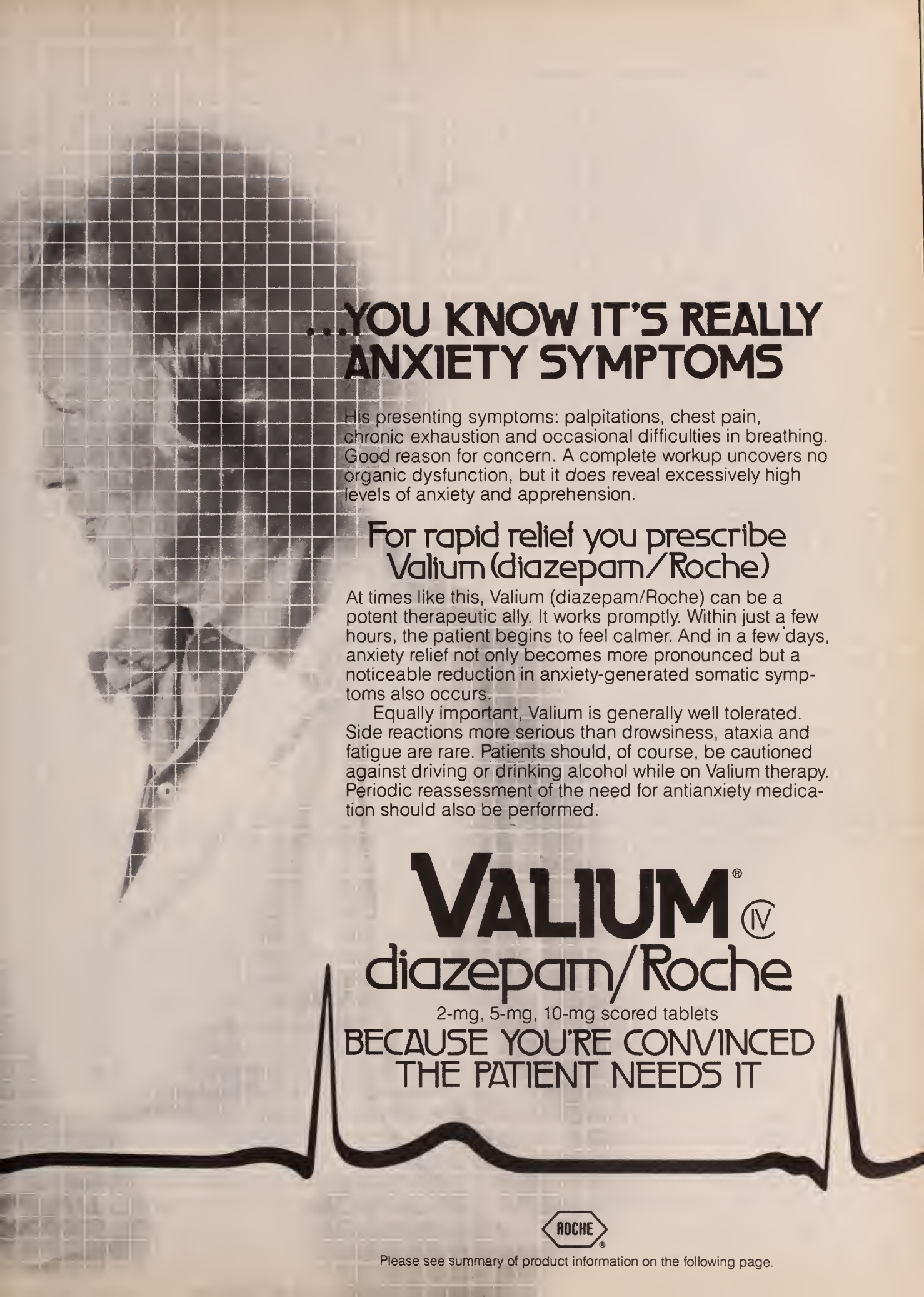
Washington, DC - Congress has approved legislation (HR 6170) aimed at reducing the number of drunk drivers on the nation's highways. The bill would provide incentive grants for three years to states that have enacted drunk driving laws which meet criteria such as requiring suspension or revocation of the driver's license of an individual convicted of drunk driving and providing that a blood alcohol concentration of .10% or greater constitutes drunk driving.

Patient Medication Info Sheets Available

Chicago, IL - Last month the AMA launched its patient medication instruction (PMI) program, with the goals of improving the effectiveness of drug therapy, strengthening the patient-physician relationship, reducing the risk of improper drug use, and increasing patient compliance. The PMIs, covering 20 of the most widely prescribed drugs, are bound in pads of 100 sheets. Minimum order is 10 pads for \$5, prepaid to AMA, P.O. Box 52, Rolling Meadows, IL 60008.

**THE PATIENT THINKS
HE HAS HEART TROUBLE...**





...YOU KNOW IT'S REALLY ANXIETY SYMPTOMS

His presenting symptoms: palpitations, chest pain, chronic exhaustion and occasional difficulties in breathing. Good reason for concern. A complete workup uncovers no organic dysfunction, but it *does* reveal excessively high levels of anxiety and apprehension.

For rapid relief you prescribe Valium (diazepam/Roche)

At times like this, Valium (diazepam/Roche) can be a potent therapeutic ally. It works promptly. Within just a few hours, the patient begins to feel calmer. And in a few days, anxiety relief not only becomes more pronounced but a noticeable reduction in anxiety-generated somatic symptoms also occurs.

Equally important, Valium is generally well tolerated. Side reactions more serious than drowsiness, ataxia and fatigue are rare. Patients should, of course, be cautioned against driving or drinking alcohol while on Valium therapy. Periodic reassessment of the need for antianxiety medication should also be performed.

VALIUM[®] _{IV}

diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

BECAUSE YOU'RE CONVINCED
THE PATIENT NEEDS IT



Please see summary of product information on the following page.

VALIUM® (diazepam/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy). The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

How Supplied: For oral administration, Valium scored tablets—2 mg, white, 5 mg, yellow, 10 mg, blue—bottles of 100* and 500;* Prescription Paks of 50, available in trays of 10 * Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25,† and in boxes containing 10 strips of 10 †

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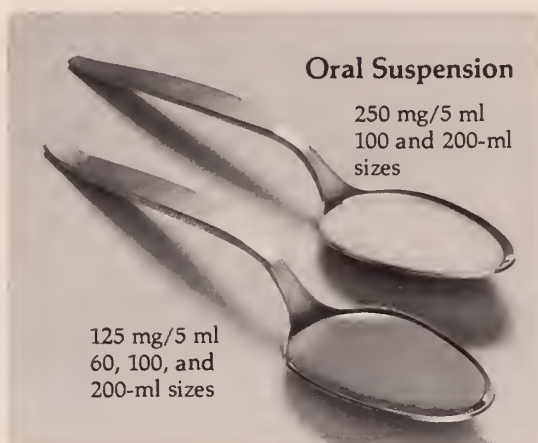
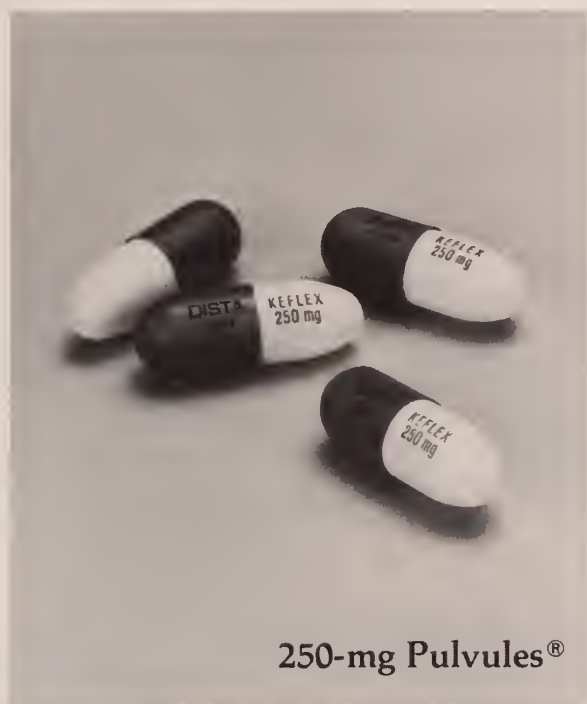
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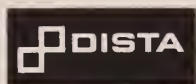
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In the treatment of insomnia

Good mornings start with restful nights.

Dalmane (*flurazepam HCl/Roche*)
patients fall asleep faster,
sleep longer and seldom awaken
with morning hangover.

Feeling well rested in the morning usually means having slept well the night before. And for insomniac patients receiving hypnotic therapy, a good morning also means awakening with few side effects from their medication. Many physicians choose Dalmane for their patients who suffer from insomnia for this very reason.

Aside from enabling patients to fall asleep more quickly and sleep longer, Dalmane seldom causes morning hangover. Most Dalmane patients feel alert and refreshed when they awaken. In 53 paired-night clinical studies comparing Dalmane and placebo in 2010 insomniac patients with a variety of secondary diagnoses, most Dalmane patients awakened more alert and refreshed, and less groggy and drowsy, than on nights when they had taken only placebo.¹ In a double-blind crossover study of

42 patients in private practice, approximately three times as many patients reported feeling refreshed and alert upon awakening after a night on Dalmane (flurazepam/Roche) compared to placebo nights.² This difference was highly significant ($p < 0.001$). And a retrospective study of 2542 hospitalized patients who received Dalmane revealed only a 3.1% incidence of side effects.³

While residual effects from Dalmane therapy are infrequent, patients should be cautioned about drinking alcohol, driving or operating hazardous machinery after ingesting the drug.

Efficacy and safety in a broad range of patient types.

Over 2000 clinical trials involving more than 10,000 patients have shown that Dalmane patients fall asleep sooner, sleep longer and experience fewer nocturnal awakenings.⁴ The safety and efficacy of Dalmane have been demonstrated in medical and surgical hospitalized patients, in patients seen in office practice and in elderly patients.⁵⁻⁸ Since the risk of oversedation, dizziness, confu-

ROCHE

sion and/or ataxia increases with larger doses in the elderly, it is recommended that the dosage be limited to 15 mg.

Moreover, the efficacy and safety of Dalmane for the treatment of insomnia have been demonstrated in thousands of patients with a variety of primary medical conditions, including cardiovascular, neuropsychiatric, endocrine-metabolic, gastrointestinal, genitourinary, respiratory and musculoskeletal disorders.¹ Dalmane (flurazepam HCl/Roche) is contraindicated in pregnancy and in patients hypersensitive to the drug.

Avoids rebound insomnia upon discontinuation.

Rebound insomnia—a worsening of sleep beyond pretherapy levels after drug discontinuation—has been reported as a potential clinical problem with some hypnotics.^{9,10} However, this problem has not been reported with Dalmane. In eight out of eight sleep laboratory studies, there were no reports of rebound insomnia.¹¹ When you prescribe Dalmane, you can be confident of efficacy that enhances therapeutic progress. Your insomniac patients can be assured of a restful night, night after night—a good start for a good morning.

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 3. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977. 4. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 5. Meyer JA, Kurland KZ: *Milit Med* 138:471-474, Aug 1973. 6. Feller HL, Gibbons B: *Med Times* 101(8):130-135, Aug 1973. 7. Jacobson A et al: *Psychophysiology* 7:345, Sep 1970. 8. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 9. Kales A, Scharf MB, Kales JD: *Science* 201:1039-1041, Sep 1978. 10. Kales A et al: *JAMA* 241:1692-1695, Apr 1979. 11. Monti JM: *Methods Find Exp Clin Pharmacol* 3(5):303-326, 1981.

For efficacy from the beginning
to the end of therapy

15-mg/30-mg capsules



Dalmane®
flurazepam HCl/Roche

stands apart

Dalmane[®]
flurazepam HCl/Roche
15-mg/30-mg capsules

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.


Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

 Roche Products Inc.
Manati, Puerto Rico 00701



**This ad
is for all those
who ever wonder
where the
money goes.**

Her name is Dana. And, she was born with impaired hearing. But this year, thanks to the therapy she will receive at her local hearing and speech center, she'll be able to clearly hear the world around her for the first time.

If you're from her hometown, your gift to your local United Way went to help make this possible. And, it was also used to help thousands of others in your community who need help.

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ORIGINAL PAPERS

Neurosurgical Complications of Breast Cancer

JOHN P. KAPP, M.D., Ph.D., J. TATE THIGPEN, M.D., RALPH B. VANCE, M.D.
and ANUPAM ROUTH, M.D.
Jackson, Mississippi

THE NEUROSURGICAL COMPLICATIONS of breast cancer almost invariably occur in the later stages of the disease. The tendency for breast carcinoma to metastasize to the brain, where the tumor is the second most common metastatic lesion, the tendency for breast carcinoma to metastasize to the spine, where the tumor is in a neck and neck position with lung cancer for first place, the tendency of the tumor to metastasize to various other bones and cause intractable pain, means that a high percentage of breast cancer patients develop a neurosurgical problem at sometime during the course of their disease. Although a cure for breast cancer is not available for those patients with distant metastases, significant palliation can be offered to most of these patients and extended survival to a significant number. Three areas in which such palliation can be offered will be discussed.

Brain Metastasis

There are two groups of patients with brain metastases to be considered — those with a single cerebral lesion, and those with multiple cerebral lesions. The advent of CT scanning has permitted the separation of these two groups with a greater degree of confidence. Patients in both groups present with headache, seizure, and/or progressive neurological deficit of various types. The single essential diagnostic test is a good quality CT scan.

From the Department of Neurosurgery and Division of Oncology, Department of Medicine and Department of Radiology, University of Mississippi Medical Center, Jackson, MS.

For the single intracranial lesion in an accessible location, surgical removal of the lesion followed by 4000 rads whole brain radiation is recommended if the patient is not terminal from systemic disease. Most lesions are considered accessible including cerebellar lesions. Lesions considered inaccessible are those involving the thalamus, basal ganglia, and brain stem.

The logic for surgical removal is as follows. First, rapid and effective palliation can be provided. The mass effect of a cerebral metastasis is often in large part related to the surrounding edema (see Figure 1). Removal of the mass removes the stimulus for edema formation, often with dramatic relief of symptoms. Secondly, because of the blood brain barrier, most drugs used for breast cancer chemotherapy have limited access to the brain and probably to the metastatic lesion within the brain. In fact, development of new disease within the central nervous system while receiving chemotherapy has been reported in 5% of breast cancer patients.¹ Finally, surgical removal of solitary metastatic lesions followed by radiation is effective therapy as far as the central nervous system is concerned. Galicich² has recently reported recurrent cerebral metastases in only 6% of patients in whom this treatment plan for cerebral metastases was followed. His data include neoplasms with multiple origins. Many of these lesions are probably less radiosensitive than the usual breast carcinoma, however, so the result should be even better in a series limited to breast carcinoma. Reported mean survival in patients following resection

of solitary brain metastases is between 7 and 14 months.³

The patient with multiple metastatic lesions is a more difficult problem. In most of these patients, surgical removal of lesions is not practical. Radiation therapy and steroids often provide for some temporary improvement. Other alternatives lie in the area of individualized drug therapy based on sensitivity testing, possibly coupled with osmotic disruption of the blood brain barrier to improve drug access.

Spinal Cord Compression

Spinal cord compression from metastatic disease is a second major unsolved problem. Of the three common routes of access of metastatic tumors to the spinal canal, hematogenous metastasis to bone, hematogenous metastasis to the epidural venous plexus, and direct extension along nerve roots, the first is the most common route for breast cancers. As these lesions spread to bone, they most commonly involve the vertebral body. The compressing lesion is thus most often anterior to the spinal cord (see Figure 2).

Recent data indicate that posterior decompression of the spinal cord by laminectomy when the compressing mass lies anterior to the cord may not adequately decompress the anterior spinal artery and its branches, and achieve optimal reversal of neurological deficits.⁴ Laminectomy also removes the only stabilizing bone structure if the vertebral body is destroyed. Perhaps for these reasons, observers have noted that the results with operative treatment, most often laminectomy, are no better than the results of radiation therapy alone.⁵

Regardless of the method of treatment, whether by surgery or radiation therapy, approximately half the patients are not improved or are worse following treatment. Stated in another way, half of the patients are improved with radiation therapy as the primary treatment. Efforts are now directed to identify these patients so that they can be treated with radiation and to devise more effective surgical methods for use in the other group. These methods include removal of masses anterior to the spinal cord and removal and reconstruction of destroyed vertebral bodies with care taken to restore proper height as well as alignment of the vertebra.

Pain is almost always the presenting symptom in patients with spine metastases, and the pain usually localizes the lesion. Any patient with breast cancer who presents with pain in the spinal region should have a careful neurological exam, and any of these



Figure 1. CT scan showing solitary metastasis with surrounding edema.

patients who have any neurological deficit referable to the spine should have a myelogram. Early diagnosis is important. If there is no doubt about the cause of the deficit and the myelogram shows less than a complete block, initial radiation therapy with high dose corticosteroids is the treatment of choice. Our indications for operative treatment are:

1. Diagnosis in doubt
2. Spinal instability
3. Cord compression by bone
4. Previous spinal cord radiation
5. Recurrence after radiation therapy
6. Progression during radiation therapy
7. Total myelographic block.

Intractable Pain

Intractable pain in breast cancer patients is most often caused by metastatic involvement of bone, and less frequently by invasion of various nerves such as the brachial plexus or the intercostal nerves. Surgical procedures for relief of intractable pain can be

performed with minimal risk, even in patients with advanced disease. Because of the problems of narcotic addiction and drug tolerance, requiring continually increasing strength and dose of narcotic agents, pain in some patients may best be managed by interruption of pain pathways. Limited life expectancy or medical complications such as coagulopathy may contraindicate operations. Judgement is required in selecting appropriate patients for surgical procedures to relieve pain, selecting the most appropriate procedure, and determining the most appropriate time in the course of the disease. We advocate the policy of considering surgical intervention for pain relief in all patients who are likely to survive for several months or more at the time recourse must be had to medication stronger than codeine. Addiction to narcotics does not in itself contraindicate operative intervention. Some patients will stop using narcotics, and others will be able to reduce the strength or dosage of their drug and minimize side effects.

Nerve fibers carrying pain impulses, with cell bodies in the dorsal root ganglia, enter the spinal cord in the dorsal grey horn, cross in the anterior commissure, and ascend to the thalamus in the lateral spinothalamic tract. They can be selectively interrupted at any of these points (see Figure 3).

In patients with chest wall pain, dorsal rhizotomy is an effective procedure. Because of overlap of sensory innervation, multiple dorsal roots, usually 3 to 5, must be interrupted. Rather than interrupt dorsal roots, we prefer to remove the dorsal root ganglion in the intervertebral foramen with a single lesion. Permanent weakness or incontinence is rare, although a laminectomy is required.

The old standard operation, cordotomy or spinothalamic tractotomy, is usually the procedure of choice when pain is unilateral and involves the extremities. The procedure is usually done with a needle electrode inserted at the C₂ level. By stimulating at various points within the spinal cord, one may be able to selectively localize fibers serving the arm or leg and create discrete lesions localized to these fibers. Pain in or near the midline is frequently not relieved by cordotomy, probably because of transmission of pain impulses in the opposite side of the spinal cord. Bilateral cordotomies are rarely done because of the problem of sleep apnea when these procedures are done at the cervical level.

Patients with bone metastases often have multiple lesions, and these often involve the spine (see Figure 4). Patients such as these are not suitable for procedures to interrupt the pain pathways because of the diversity of pain sources. For these patients tran-

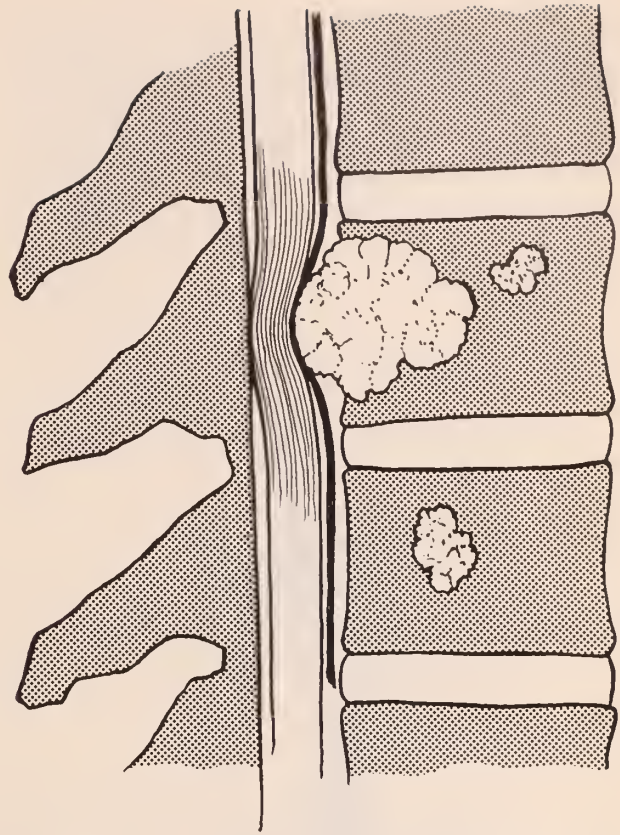


Figure 2. Breast cancer metastasis in a vertebral body, showing effect on the spinal cord.

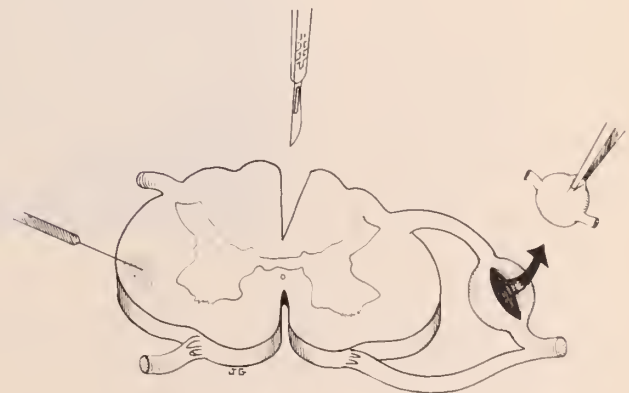


Figure 3. Anatomical sites for interruption of pain (a) dorsal root ganglion (b) crossing fibers in anterior commissure (c) lateral spinothalamic tract.

sphenoidal hypophysectomy can be offered. Relief of bone pain with this procedure is achieved in 80%-90% of patients,⁶ varying to some extent on patient selection criteria. Relief of pain is often dramatic and is usually noted in the recovery room. Postoperative endocrine management requires standard adrenal and thyroid replacement and is not compli-

cated. Transient postoperative diabetes insipidus is the rule, but this often subsides spontaneously within two weeks or is so mild that the patient can manage it by controlling fluid intake despite moderate thirst. In most other patients it can be controlled with oral clofibrate. A rare patient will require vasopressin, which can be administered as a nasal spray.

Proposed mechanisms for the beneficial effect of hypophysectomy on breast cancer patients include reduction of estrogen and androgen production by reduction of gonadotropin and ACTH, reduction of prolactin, and reduction of growth hormone.⁷ Pain relief is achieved in many patients who do not have objective tumor regression. Interruption of a feedback loop between the hypothalamus and pituitary involving the endorphin system has been proposed as a possible mechanism,⁸ although this remains controversial.

In addition to relief of pain in 80%-90% of patients, objective tumor regression can be expected in a substantial number of patients, depending on criteria used to select patients for operation. An objective response rate of 42% has been reported if no selection criteria are applied.^{8, 10} If only oophorectomy responders are included, the objective response rate is 85% to 90%.^{9, 10} In patients with tumor positive for estrogen receptors, the response rate is 65%,⁹ and in patients with estrogen and progesterone receptor positive tumors the response rate is 80%.⁹ Other factors favoring objective remission are long disease-free interval after diagnosis, age over 60 years, and metastases localized mainly to bones.⁶

Summary

As better systemic cancer control has been achieved in patients with breast cancer, complications involving the nervous system have become more common and require frequent consideration in individual patient management. We have presented our current approaches to these various problems, and the logic and data supporting these approaches. Solitary intracranial metastatic lesions respond to surgical excision and whole brain radiation. Most intractable pain problems can be managed without resorting to large doses of narcotics. Major unsolved problems remain, especially in the management of multiple intracranial metastatic lesions, and in the management of spinal cord compression due to metastatic tumor. An ongoing search for the best solution to these problems, as well as steady ad-



Figure 4. Bone scan showing multiple midline metastatic lesions from breast carcinoma.

vances in the control of systemic disease, should progressively improve the outlook for patients with breast cancer. ★★★

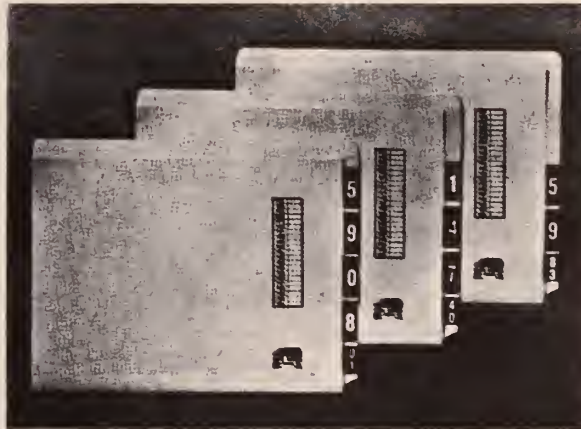
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References

1. Pearlman, A. W.: Influence of brain metastases on the chemotherapeutic management of breast cancer. Mount Sinai J. Med. 44:515-520, 1977.
2. Galicich, J. H., Sandaresan, N., Thaler, H. T.: Surgical treatment of single brain metastasis. Evaluation of results by computerized tomography scanning. J. Neurosurg. 53:63-67, 1980.
3. White, K. T., Fleming, T. R., and Laws, E. R.: Single metastasis to the brain. Surgical treatment in 122 consecutive patients. Mayo Clin. Proc. 56:424-428, 1981.
4. Doppman, J. L., and Girton, M.: Angiographic study of the effect of laminectomy in the presence of acute anterior epidural masses. J. Neurosurg. 45:195-202.
5. Cobb, C. A., Leavens, M. E., and Eckles, N.: Indications for non-operative treatment of spinal cord compression due to breast cancer. J. Neurosurg. 47:653-658, 1977.
6. Tindall, G. T.: Hypophysectomy in the treatment of disseminated carcinoma of the breast and prostate gland. South. Med. J. 69:579-583, 1976.
7. Tindall, G. T., and Mauldin, B.: Transphenoidal hypophysectomy. AORN Journal. 33:246-252, 1981.
8. Tindall, G. T., Nixon, D. W., Christy, J. H., and Neill, J. D.: Pain relief in metastatic cancer other than breast and prostate gland following transphenoidal hypophysectomy. J. Neurosurg. 47:659-662, 1977.
9. Pearson, O., Brodkey, J., and Manni, A.: Hypophysectomy for stage IV breast cancer. Surg. Clin. N. Amer. 58:809-817, 1978.
10. Ray, B. S.: Hypophysectomy as palliative treatment. JAMA 200:974-975, 1967.

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Puerperal Ovarian Vein Thrombosis

MICHEL E. RIVLIN, M.D., Moderator

G. RODNEY MEEKS, M.D., Series Coordinator
Jackson, Mississippi

DR. GRIFFIN: G.O. is a 30-year-old, G4, P3, black woman who was admitted in labor at 36 weeks gestation by menstrual dates. She had an uneventful prenatal course. Her previous pregnancies were uncomplicated and produced healthy infants. Membranes were artificially ruptured, and one hour later she delivered over an intact perineum without anesthesia. The female infant weighed 2120 grams and had Apgar scores 9/10. Total duration of labor was four hours. The placenta delivered spontaneously and appeared to be complete. A 3 cm cervical laceration was repaired without difficulty and estimated blood loss was 500 ml.

The patient requested puerperal sterilization. Preoperative work up included normal chest x-ray and normal electrolytes, a hematocrit of 30% (35% before delivery) and a white cell count of 13,000 mm.³ A Pomeroy tubal ligation was carried out under general anesthesia 24 hours postpartum through an infraumbilical incision. The uterus, tubes, and ovaries appeared healthy at surgery. On the second postoperative morning her temperature was 99.9° F, and both incision and uterus were tender to palpation.

DR. RIVLIN: How does one respond to a mild temperature elevation after delivery and surgery?

DR. HARPER: One should consider the possible causes of the fever including endometritis, urinary tract infection, mastitis, wound or chest infections, and deep vein thrombosis.

DR. BUSH: Following a thorough examination with emphasis on the urinary tract, wound, breasts, lungs, uterus, and episiotomy, I would obtain a white cell count and a urinalysis.

DR. BURRUS: A morning temperature elevation especially with a tender uterus is significant, and I

Panelists: *Charles C. Bush, M.D. of Jackson, Swan B. Burrus, M.D. of Oxford, and Gerald H. Harper, M.D. of Laurel. J. Brooks Griffin, M.D., Jackson, presents the case. Charles E. Sampson, M.D., of Jackson, comments.*

would not let her go home. In addition I would culture the cervix and urine.

DR. GRIFFIN: The third postoperative day her temperature was 102.6°. The abdomen was mildly distended with minimal rebound tenderness and decreased bowel sounds. The uterus and incision continued to be tender. There was no evidence of mastitis, cystitis, or deep vein thrombosis. The white cell count was 23,400 mm³. Blood and cervix cultures were obtained.

DR. BUSH: This patient has endomyometritis which is possibly related to the cervical laceration. I would start antibiotics, probably cefoxitin, after the appropriate cultures were obtained.

DR. HARPER: She is seriously ill and I would start a more aggressive antibiotic regimen such as clindamycin and tobramycin. I would also order supine and erect abdominal x-rays as well as chest films to look for evidence of intraperitoneal or pulmonary sepsis.

DR. GRIFFIN: The patient was treated with cefoxitin but had no significant response following 24 hours of therapy. Both temperature and white cell count remained elevated. Vague lower abdominal tenderness and guarding persisted. A 16-week tender uterus and adnexa were noted on pelvic examination, but no adnexal masses were outlined. Abdominal x-rays indicated a minor ileus, and chest films were negative.

From the Department of Obstetrics and Gynecology, University Medical Center, Jackson, MS.

DR. BUSH: Generally I give patients 36 hours on my first choice antibiotic regimen. I would now alter therapy to clindamycin and tobramycin. Do you have results of any cultures?

DR. GRIFFIN: Blood and cervix cultures were negative. On the fourth postoperative day antibiotic therapy was altered to cleocin and tobramycin. Following 48 hours on this combination and a total of 72 hours of antibiotic therapy the clinical picture remained unchanged. However, she was having bowel movements.

DR. HARPER: A CAT scan or gallium scan may delineate any purulent collections especially in this patient whose infection is not responding to broad antibiotic coverage. A sonogram may be just as good. At this point, I would have my colleagues examine her also. The situation requires an objective reassessment to determine if the primary physician is missing something, and to suggest other investigations or alternative therapies.

DR. RIVLIN: A pelvic sonogram showed an empty postpartum uterus and no adnexal masses. By the seventh postoperative day the clinical situation had not changed. She did not appear extremely ill; however, her temperature and white cell count remained elevated and abdominal tenderness and distension persisted. All cultures yielded no growth. How should one proceed now?

DR. BUSH: I would first reexamine her. If I did not find convincing evidence of peritonitis or an abscess, I would suspect pelvic thrombophlebitis because she has not responded to an adequate trial of antibiotics.

DR. HARPER: She appears less sick than her temperature suggests. This finding favors the diagnosis of pelvic thrombophlebitis.

DR. BURRUS: On repeat pelvic examination and on sonogram no adnexal mass was identified. Therefore, adnexal torsion or an impending rupture of a tuboovarian abscess appears unlikely. I also favor a diagnosis of pelvic thrombophlebitis, and would start full anticoagulant therapy with heparin.

DR. RIVLIN: The question of whether to start a 48 hour trial of heparin was discussed but her physicians were concerned that her clinical condition might deteriorate. There was strong clinical suspicion that a tuboovarian abscess might be present in spite of the negative sonogram. The situation was discussed with the patient, and the significance of surgery with a possible pelvic clearance was discussed with her in detail. The decision was then made to proceed to surgery. A preoperative pyelogram was normal.

The next day (postoperative day 8) examination

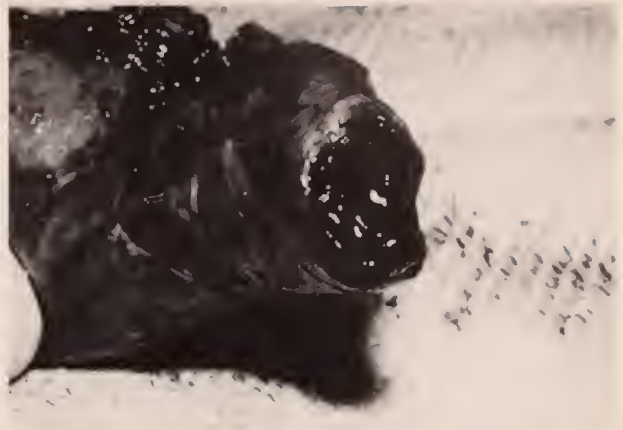


Figure 1. Thrombosed ovarian vein.

under anesthesia confirmed a uterus enlarged to 16 weeks size and additionally revealed a large mass at each uterine cornu. These were not pelvic masses, but were best felt on abdominal examination at the level of the umbilicus.

The abdomen was entered through a vertical midline incision. Clear fluid was present in the peritoneal cavity but there was no evidence of peritonitis. The adnexal masses were comprised of grossly edematous tubes, and relatively normal ovaries. On palpation, obviously thrombosed ovarian veins extending to the level of the kidneys were noted. Now, does one proceed with the surgery or close the abdomen and treat with heparin?

DR. BURRUS: The tubes were tremendously edematous rather than infected and the ovaries appear separate from this process. Therefore, this is not a tuboovarian abscess. If I did proceed with surgery, I would administer heparin during the procedure and would be prepared to spend extra time obtaining hemostasis.

DR. HARPER: The problem with surgery is that one manipulates the vessels during the procedure and an embolus may be thrown off. I would treat with heparin.

DR. RIVLIN: Because the infection which started all of this was probably in the uterus, a total hysterectomy was performed. The uterine vessels were not thrombosed, but the ovarian veins contained thrombi about 2 cm across with no obvious purulent material in the vessels (see Figure 1). The procedure to this point did not entail much handling of the vessels but a decision to proceed further would have, of necessity, involved manipulation of the ovarian plexus. At this stage Dr. Charles Sampson, director of the Gynecology Division, was consulted. I will ask him to comment now.

DR. SAMPSON: I felt the adnexa should be removed and the ovarian veins ligated as high as possible. This posed significant problems because the vessel walls were fragile. They ruptured easily expelling clot but causing little active bleeding. Near the vena cava the vessels still contained thrombus and the dissection was stopped. The veins were then oversewn.

DR. HARPER: If the thrombus extends as far as the vena cava a vascular surgeon might be consulted to ligate the cava or place an umbrella to prevent embolization.

DR. SAMPSON: One would have had to go above the renal veins and I would hesitate to do that. Furthermore, vena caval ligation may leave the patient with long term debilitating sequelae such as recurrent lower limb phlebitis, pain, edema, and ulceration.

DR. BUSH: If one decided to ligate the vena cava, one probably should ligate the ovarian veins bilaterally as well. However, this patient did not have embolization and these cases do not ordinarily embolize if treated with heparin. Vena cava ligation is usually reserved for patients who have actual pulmonary embolism while on heparin. Therefore, I would not recommend ligation at this time.

DR. RIVLIN: Heparin was started in the recovery room. She became afebrile 96 hours later and remained so until discharge. All cultures taken at surgery including those from the vein walls were negative. Her total hospital stay was 19 days. The patient was sent home on warfarin and conjugated estrogens. The warfarin was discontinued six weeks later. She remains well at the present time. Pathologic findings included endomyometritis, hematoxyosalpinges, and thrombosed ovarian veins. The vein walls were thickened by severe edema and contained organized thrombus (see Figure 2). What is the underlying cause of ovarian vein thrombosis?

DR. HARPER: Almost always it is preceded by infection or trauma from surgery.

DR. BURRUS: I suspect that bacteria entered at the site of the cervical tear causing an endometritis, parametritis, and salpingitis. Subsequent vessel wall damage culminated in ovarian vein thrombosis.

DR. BUSH: Another possibility is that premature labor occurred in this patient as a result of pre-existing chorioamnionitis. This would explain the endometritis which then spread to the adnexa and veins.

DR. RIVLIN: Munsick and Gillanders recently reviewed the literature concerning the syndrome of puerperal ovarian vein thrombophlebitis.¹ Overt or covert bacterial metritis is relatively well doc-

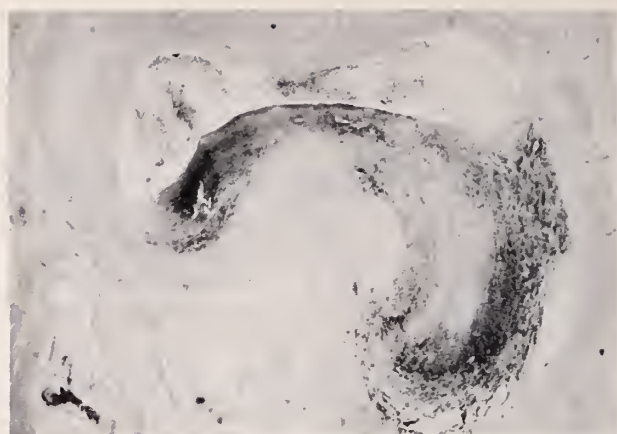


Figure 2. Photomicrograph of ovarian vein illustrating the marked edema of the vein wall and organized intraluminal thrombus.

umented as the usual cause. A frequent finding is a characteristic unilateral or bilateral tender linear abdominal mass originating near the uterine cornu and disappearing in a cephalic and lateral direction. Examination under anesthesia may be helpful in delineating the mass. Sonography can provide the diagnosis if the sonographer is aware of the entity and extends scanning upwards. The authors strongly recommend a trial of heparin therapy even if the diagnosis is made at celiotomy. However, 54 of 66 cases reviewed were in fact treated by a wide variety of operative procedures. This may be due to the relative unfamiliarity of many physicians with the condition or to the difficulties entailed in reaching a diagnosis prior to laparotomy.

To summarize, a 48 hour trial of heparin therapy appears to be warranted in cases with puerperal infection unresponsive to antibiotics. Obviously this does not apply to those patients with clear-cut indications for surgery such as an appendicitis, spreading peritonitis, or enlarging pelvic abscess. While puerperal ovarian vein thrombophlebitis is an uncommon condition, it is worthwhile keeping in mind since it may not be as rare as is generally reported.

I would like to thank our panelists for an excellent discussion and would once again emphasize how much we in the department enjoy the company of our clinical associates at these presentations. I would also like to acknowledge Dr. Jack Lewin of our pathology department, who provided the illustrations. ★★★

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Bibliography

1. Munsick, R. A. and Gillanders, L. A.: A review of the syndrome of puerperal ovarian vein thrombophlebitis. *Obstet. Gynecol. Surv.* 36:57-66, 1981.



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Myiasis: *Dermatobia hominis* (Linnaeus) in Mississippi (Diptera: Phoridae)

JOHNNY D. OUZTS, Ph.D., R.P.E., and A. W. LINDSEY, JR., M.D.
Cleveland, Mississippi

CUTANEOUS MYIASIS in Mississippi in direct association with common fly species has been confined to those affecting livestock. The appearance of the genus *Dermatobia* was considered rare and therefore prompted the addition of limited information to the literature.

The human bot (warble), *Dermatobia hominis* (= *D. cyaniventris*), is confined (1) to the Americas and has a wide distribution ranging from Mexico to Argentina with reports of its presence along the shores of the Carribean. Larvae of this species (2) are important pests of livestock in its native area. Cases have been reported which have resulted in extreme conditions in young children and deformities in adults.

Case Report

An examination of a male caucasian was made on March 11, 1981, two and one-half weeks after his return from a hunting trip in the Central American country of Belize. Noticeable lesions were present on the upper torso, specifically the left shoulder (scapula) in an area approximately 15.24 cm from the deltoid crest and 45.72 cm from the dorsal midline.

Review of the activities of the patient yielded data showing that an area of 8-10 square miles in the country of Belize had been hunted. The area involved is located on the northwestern border of Belize: west of the town of Orange Walk, near the Rio Hondo River on the border of Yucatan, Mexico and Belize (latitude 18° 45' north and longitude 88° 45' west). The area was described as a rain forest with moderate to heavy unidentified mosquito and other arthropod populations.

From the School of Arts and Sciences, Delta State University, Cleveland, Mississippi.

Cutaneous Myiasis in Mississippi in direct association with common fly species has been confined to those affecting livestock. The appearance of the genus *Dermatobia* was considered rare and prompted the authors to present this case.

Appeasement of the affected area and the oral administration of tetracycline failed to provide the desired response. Constant drainage (weeping) of the affected area required bandaging and routine changes. Due to the lack of improvement, the patient consulted an entomologist for supplemental information. Exudate taken from the lesion contained bits of the exuvium of a dipterous larva with the characteristic spines intact.

Surgical excision was recommended with emphasis placed on removing the larva without cuticular disturbance. Surgery was performed on April 9, 1981. A third instar larva of *D. hominis* exhibiting the characteristic spiracles, heavy microspines, and well developed mandibles was removed with forceps without cuticular disruption.

The unsutured incision was packed with iodoform-treated gauze, and the patient was recalled for periodic evaluations after surgery with dismissal on April 17, 1981.

★★★

Cleveland, MS (38733)

References

1. Dondero, Timothy J., Jr, Schaffner, William, Athanasiou, Robert, and McGuire, William: Cutaneous myiasis in visitors to Central America. *South. Med. J.* 72(12):1508-11, 1979.
2. Biery, Terry L., Clegern, Robert W., and Hart, William W.: Two cases of phorid (Diptera: Phoridae) myiasis in Texas. *J. Med. Entomol.* 15(2):122-3, 1979.

Sickle Cell-Beta-Thalassemia: A Common Phenocopy of Sickle Cell Anemia

MARTIN H. STEINBERG, M.D., JUNIUS G. ADAMS, Ph.D., and RONNIE HENDRIX, M.D.
Jackson, Mississippi

SICKLE CELL ANEMIA (HbSS) is present in about 1 of 1500 black adults¹ and is a common disorder in Mississippi. There are national and local programs designed to identify heterozygotes with sickle cell trait (HbAS) and provide genetic counseling to those who desire it. However, the value of such programs depends upon the ability to reliably detect not only HbAS or HbSS but other frequent disorders of hemoglobin structure and synthesis which can interact with the sickle hemoglobin gene and produce disorders of clinical importance.

A 6-month-old child was referred to us with the assumed diagnosis of HbSS. While the father had HbAS, the mother was said to have only normal hemoglobin. The family stress and confusion caused by these findings could easily be resolved by more critical analysis of readily available laboratory tests. Since problems of this type are not uncommon, we thought it useful to report this family.

Methods

Cell counts and erythrocyte indices were obtained using a Coulter ZBI electronic cell counter. Hemoglobin electrophoresis was done in cellulose acetate membranes in tris-EDTA-Borate buffer, pH 8.6 and on citrate agar plates in pH 6.1 buffer. Hemoglobin fractions were quantified spectrophotometrically after their elution from polyacrylamide gels. HbF was measured by the technique of Betke.²

Results

The family pedigree is shown in Figure 1. Table 1 presents the hematologic and electrophoretic findings, and the blood films are illustrated in Figure 2.

From the Hematology Research Laboratories, VA Medical Center and Department of Medicine, University of Mississippi School of Medicine, Jackson, MS and the MYL Clinic, Yazoo City, MS

While sickle cell anemia is the most prevalent severe sickling disorder in this country other mixed heterozygous sickling hemoglobinopathies are commonly encountered. Failure to appreciate the presence of these conditions can provoke serious errors in family counseling. We present the findings in a family in which the proband, with sickle cell- β^0 -thalassemia, was initially suspected of having sickle cell anemia despite an ostensibly normal mother. Clues to arriving at the correct diagnosis in cases of this type are discussed.

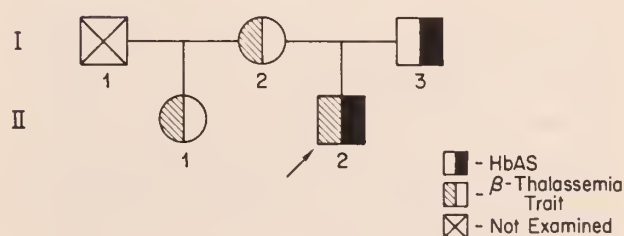


Figure 1. Family pedigree.

The mother, I-2, has β -thalassemia trait on the basis of microcytosis, hypochromia, basophilic stippling of her erythrocytes (see Figure 1a) and an elevated level of HbA₂. The father, I-3, has sickle

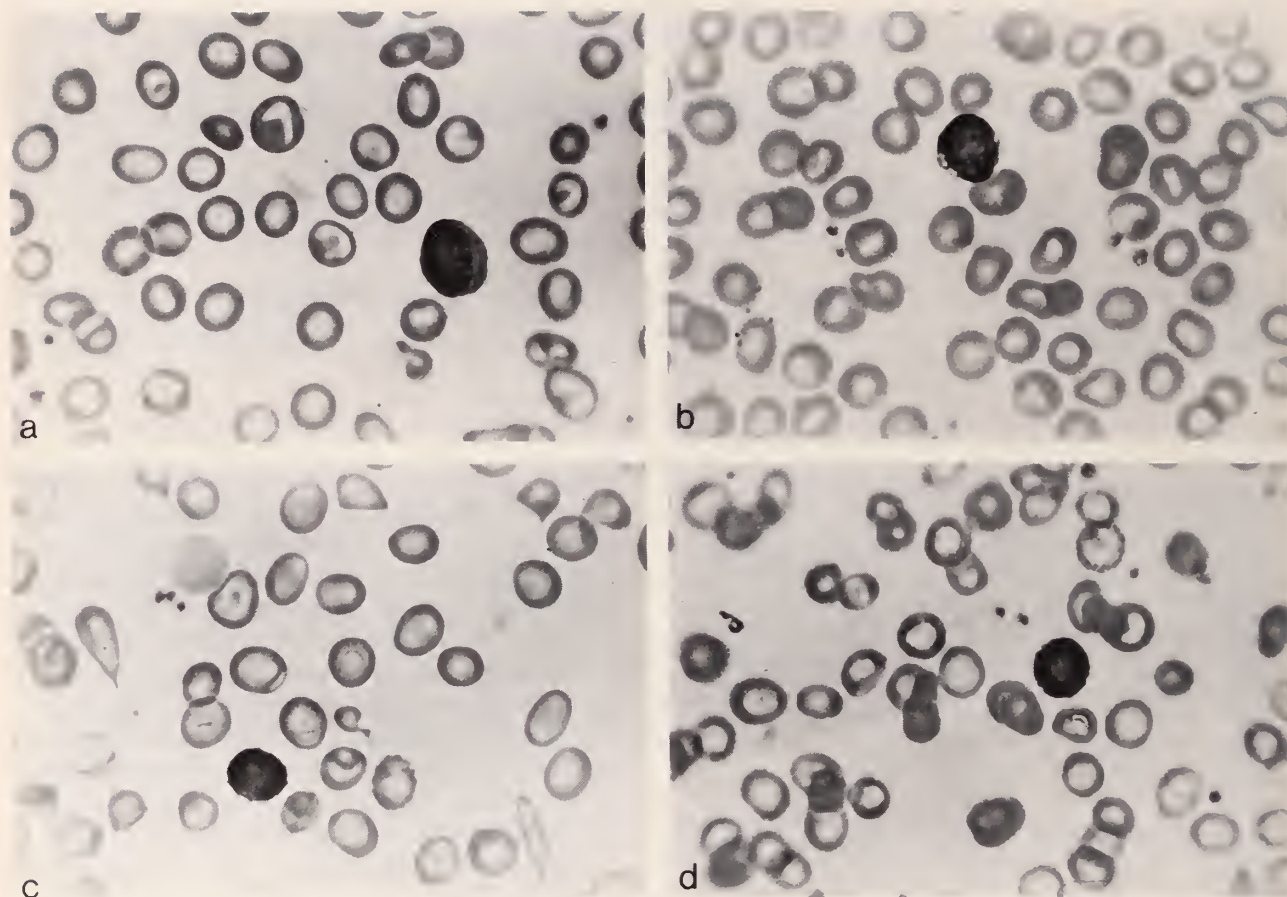


Figure 2. a-d Peripheral blood films (1000 \times).

cell trait with a normal hemoglobin level, normal erythrocytes (see Figure 1b) and a HbS level of 42%. His HbA₂ is normal. The proband, II-2, is a mixed heterozygote with HbS- β^0 -thalassemia characterized by anemia, microcytosis, sickle cells in the blood film (see Figure 1c), HbS and F on electrophoresis, an elevated level of HbA² and a mother with heterozygous β -thalassemia. A half sister, II-1, also has heterozygous β -thalassemia (see Figure 1d), but with an exceptionally high HbF level. This might reflect the coexistence of one of the forms of persistent fetal hemoglobin.

Discussion

Genetic and gene mapping studies have shown that there are in each individual two genes, one on each chromosome number 16, which direct the synthesis and code for the structure of the β -globin chain.³ In normals, both genes code for β^A globin chains which, when combined with α -globin chains, form the major adult hemoglobin, HbA ($\alpha_2\beta_2$). Indi-

viduals with HbAS have a β^A -gene and a β^S -gene which codes for the sickle hemoglobin β -chain. The sickle β -chain is characterized by a single amino acid substitution at position 6 (glutamic acid valine).³ These individuals characteristically have about 40% HbS ($\alpha_2\beta_2^S$). The homozygote for the β^S gene has HbSS and since no β^A is present, cannot produce HbA.

In β -thalassemia, the structural gene for β -globin is normal, however, the production of β -globin is either greatly diminished (β^+ -thalassemia) or totally absent (β^0 -thalassemia).⁴ The molecular mechanisms underlying these defects have been worked out in many instances. Heterozygotes for either type of β -thalassemia generally have very mild anemia, microcytic red cells, and as a convenient marker for this condition, elevated levels of the minor adult hemoglobin, HbA₂ ($\alpha_2\delta_2$). Homozygotes usually have a severe transfusion dependent hemolytic anemia.

TABLE 1
HEMATOLOGIC AND ELECTROPHORETIC DATA

	Hb	Hct	MCV	HbA ₂ %	HbF%	HbS%
I-2 (Mother)	12.1	40.9	68	5.5	0.7	—
I-3 (Father)	14.0	41.3	82	3.0	0.1	42
II-1 (Half-Sister)	10.5	31.9	59	6.0	6.4	—
II-2 (Proband)	7.6	22.6	68	5.2	*	>80
Normal	13-16	38-55	80-85	2.0-3.4	<1	—

* Not quantified.

The β^S gene is present in about 8% of our black population⁵ and about 1% of this same group carry a gene for β -thalassemia. It is therefore common to see individuals who are mixed heterozygotes for both disorders and have sickle cell- β -thalassemia (HbS- β -thalassemia). In our proband, the lack of HbA indicates that both he and his mother have the β^O -thalassemia gene, thus he has HbS- β^O -thalassemia. Since no HbA is present superficial analysis of his hemoglobin suggests he has HbSS. However, the family studies conclusively show this is not the case. In addition, he has microcytic hypochromic erythrocytes which are not typical of HbSS and an elevated HbA₂ which helps confirm the presence of a β -thalassemia gene.

Individuals with HbS- β^+ -thalassemia are also commonly seen. In this instance about 20%-30% of the hemoglobin is HbA, HbA₂ is elevated and the erythrocytes are hypochromic and microcytic. This disorder should not be confused with sickle cell trait since anemia, splenomegaly and symptoms related to sickling may occur. Sickle cell trait causes no clinical or hematologic problems.⁵

Patients with HbS- β^O -thalassemia can have all of the complications of patients with HbSS although, in general, they may have milder disease. They should have close medical supervision especially during infancy and childhood when severe infectious complications are most likely.

While the diagnosis of HbSS is not difficult, phenocopies of this disorder, such as HbS- β^O -thalassemia do exist and call for a constellation of simple laboratory tests to confirm their presence. We have

recently presented an approach to the diagnosis of the sickling disorders.⁶ In the family presented, considerable anxiety was precipitated by the presence of a child suspected of having HbSS but with a "normal" mother. Even greater consternation is caused when the "normal" father and a mother with HbAS have a child with "HbSS." Careful family testing and hematologic evaluation can avoid these problems.

Acknowledgements

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References

1. Motulsky, A. G.: Frequency of sickling disorders in U.S. Blacks. *N. Engl. J. Med.* 288:31-33, 1973.
2. Huisman, T. H. J.: Human hemoglobins in biochemical methods in red cell genetics. J. J. Yunis, editor. New York, Academic Press, 391-504, 1969.
3. Bunn, H. F., Forget, B. G. and Ranney, H. M.: Human hemoglobins. New York, W. B. Saunders, 1977.
4. Weatherall, D. J. and Clegg, J. B.: The thalassaemia syndromes. Oxford, Blackwell Scientific Publications, 1981.
5. Heller, P., Best, W. R., Nelson, R. B. and Becket, J.: Clinical implications of sickle-cell trait and glucose-6-phosphate dehydrogenase deficiency in black male patients. *N. Engl. J. Med.* 300:1001-1005, 1979.
6. Steinberg, M. H. and Adams, J. G.: Laboratory diagnosis of sickling hemoglobinopathies. *S. Med. J.* 71:413-416, 1978.



But Doctor, What About My Financial Health?

MICHAEL GARTNER

IT WOULD BE PRESUMPTUOUS of me to talk about what's right and wrong, or good and bad, in your profession. I will try to tell you what the public thinks of you. You can make up your own minds about whether it's good or bad.

The cover of the March 9, 1929, edition of the *Saturday Evening Post* featured Norman Rockwell's interpretation of his and the then-public attitude toward the physician. It shows an older man and a little girl looking on as the doctor puts a stethoscope to a doll's chest. The painting is called "Doctor and Doll" — and, as an aside, if you owned the painting today you wouldn't have to worry about where your next dollar was coming from. The child adores the old doctor. In 1929, Rockwell's physician was warm, witty, loving and very personal. No one would ever consider suing Rockwell's doctor for malpractice — even if he were, in fact, all thumbs in the operating room.

The situation didn't change much during the next

decade. Families who remember the depression tell story after story of doctors who traded tonsils for chickens, of doctors who drove miles through the night to deliver babies, of doctors who had little regard for money and who had never heard of tax shelters.

The media, attempting to reflect public opinion more than make it, continued to depict the family doctor more or less as Rockwell had. Through the 1940s, young Dr. Kildare was gently taught by old Dr. Gillespie about medical ethics and the doctor-patient relationship. At the same time, Dr. Gillespie taught a whole generation of fans how to view their family physician and how to communicate with that wise and wonderful person. To my knowledge, Dr. Gillespie never had a stockbroker, never owned a pair of Gucci loafers, never drank too much, never aspired to anything but loving service to his adoring patients. His only and dearest mission was to heal and to serve.

I'm sure that that remains your mission today. But somewhere along the way, you lost your image. According to an Iowa Poll conducted in 1979, people in that state overwhelmingly still consider you friendly, gentle, and sympathetic. But more than half of the people in the state say their doctors won't make house calls. About a third think your fees are

Michael Gartner is editor and president of the *Des Moines Register and Tribune*. He is also vice chairman of the Central Iowa Health Association, a group concerned about rising medical costs. This article, taken from the *Des Moines Register*, October 27, 1980, was originally a speech to the Iowa Medical Society.

unfair (and, I should add, they mean unfairly high, not unfairly low), and a quarter say they can't even get hold of you on the phone without going through an answering service. According to another poll — a Gallup Poll — the number of young people who today want to be doctors is roughly half the number of just five years ago. And yet another poll — a Roper Report — indicates that a major attraction of medicine to today's young people is the money. Ah, romantic youth!

I don't know what has happened, but it probably has to do with the age we live in. We now live in an age of cynicism and inflation. We live in an age that demands credibility, accountability, and full disclosure — a watching of pennies. All of these factors place a psychological distance between Norman Rockwell's loved and loving practitioner and the physician imaged by the people of today.

And I think the fault is mostly yours. Today you can cure ills that were once deadly, you can spot ailments that were once unseeable, you can transplant hearts and kidneys, and devise machines that cleanse my organs or help me breathe. Today, you can perform miracles. But, you don't seem to be able to explain yourselves and your business. Or, maybe you don't want to.

Today, you need a good public relations man. You need to convince the public that you care about their financial health almost as much as you care about their physical well-being. If, of course, you do.

When I go to the doctor, you will patiently explain to me just what causes me to double-up in pain at precisely 10:15 every morning. You will painstakingly draw me diagrams, show me pictures, and lead me through explanations. We talk about my X-rays, my electrocardiogram, my blood pressure readings. You are not embarrassed to talk to me about my urine, my stool, or my sex life.

But, you all but blush and shy away from talking about your bill. That comes in the mail — if you don't insist on cash right away at the desk out front. There are no explanations, no diagrams, no justifications. I'm embarrassed to ask you about money, too, so I just grumble to the folks at the tavern, to the guys at the office, and to the family at the dinner table. And, that doesn't do either one of us much good.

Why don't you tell me what a night is the hospital is going to cost? Why don't you tell me that I could save \$312.14 if I'd be willing to take care of my ailment as an outpatient? Why don't you tell me that a test is marginal, that it costs \$240? Why don't you encourage me to leave the hospital sooner?

I think your patients would love you for this —

just as that little girl loved Norman Rockwell's doctor. You're rich, and, for the most part, your patients are not. They're embarrassed to ask you about money because they're embarrassed to admit to you that it's a concern. They know it's no concern to you — you with your Mercedes Benz automobile, your meetings in Hawaii, your home south of Grand, your ski condominium in Colorado, and your tax shelter in Texas.

Your patients, of course, can't do much more than grumble. But I'll tell you what's happening in this state. Those patients are grumbling at the office, and their employers and their union leaders are listening. And now they're starting to grumble, too, and that probably will get your attention.

The union leaders are upset because they know that every additional dollar a company pays in medical insurance is a dollar lost for wages. The employers are upset because they are discovering that medical costs are their fastest rising costs.

So, in a remarkable alliance around the nation, labor and management are ganging up on you. They are concluding there are but two ways to cut costs: regulation or competition. Regulation being anathema to them as it is to you, they are seeking to foster competition in your business. They're butting in — because it's their dollars involved.

In central Iowa, some of us are butting in because hospital utilization is so high — roughly 17 percent above the national average. We're doing this not because we want to interfere in your lives — God knows there are more exciting places to be than meetings of the Central Iowa Health Association — but because you are unwilling to act on your own. We have repeatedly said we'd fold up our tent and go home if you could get utilization to drop just 10 percent. We get no response. Yet a Blue Shield-Blue Cross study shows that the premiums at Meredith Corp. would drop 14 percent if you would handle certain routine procedures on an outpatient basis — procedures that are regularly treated on that basis in New York and California. You could make the change overnight.

We have started to look at statistics. We can identify, after much work, the doctors among you who charge too much, who abuse the use rates of hospitals, who are as interested in the chisel as they are in the scalpel. You have known all along who these people are. Why haven't you policed your own profession? Why do you leave it up to John Deere to raise hell about these folks? Why didn't you do it yourself years ago? If you had done so, I could spend more time playing tennis or running at the Y — keeping myself fit — instead of going to meetings

about my rising medical costs.

You just haven't worried about my costs. And I think you should have been doing so — every bit as much as you worry about my body.

So what's going to happen, I'm sure, is that some Health Maintenance Organizations are going to spring up in Iowa. That's a term that raises your blood pressure, I'm sure, but you must see them coming. Some will fall, some will succeed. Some will have top-notch doctors, some won't. But the good ones will thrive. And they'll grow for one simple reason — the care will be less costly than traditional medical care.

Those of us who enroll in HMOs will be giving up something wonderful — the doctor-patient rela-

tionship that was built over the years. But money talks. In HMOs the patient-doctor relationship is clearly defined in terms of economics as well as in the traditional terms of care and caring. That's important these days — to labor unions, to employers, to insurers and, increasingly, to the average patient as well.

It's too bad, I suppose, that it has come to this. It's too bad because, for a while at least, all of this will strain and stain relationships in the community. It needn't be that way, but that seems to be the way it is developing.

And, in the view of the public, you've brought it on yourself.

★★★

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Business, Medical Group Hopes To Cut Health Care Costs

RONNIE MILLER

CONSUMERS have to become more price-conscious if health care costs are to stabilize, according to Dr. Ellis Moffitt, chairman of the board of trustees of the Mississippi State Medical Association.

Moffitt told a group of Jackson area businessmen last night that he hopes a newly formed coalition of businessmen, insurance agents and physicians will be able to stabilize health care costs in Mississippi by the first of next year.

"There's one thing we can sum up to begin with about health care costs; it's expensive and it's going up," he said.

Moffitt said the idea of a coalition is "a little bit different and unique," but hopes that by opening up dialogues between physicians, labor, business and insurance, progress can be made in easing the increasing cost of health care.

About eight physicians, 24 businesses, several insurance representatives and the Jackson Chamber of Commerce currently are studying ways to bring health care costs down in Jackson, he said.

Among the factors that have contributed to increased costs are longer life expectancies and high technology.

More people using more services also have caused prices to increase, Moffitt said. For instance, in 1967, only 650 Americans with kidney failure were receiving hemodialysis due to the limited number of facilities available. In 1980, there were 64,000 people on dialysis.

Unnecessary use of health care services also has contributed to increased costs. For instance, 50 to 60 percent of emergency room visits are not emergencies and could possibly be treated more cheaply by a physician in his office, Moffitt said.

"People can consume as much health care as someone else can pay for," Moffitt said.

Local, state and federal regulations also are a factor. He said 25 percent of the charges at hospitals are due to regulations. Malpractice insurance, which costs \$12,000 a year for a neurosurgeon and \$10,000

a year for an obstetrician-gynecologist, also serve to boost costs.

The consequence is that U. S. Health care costs have jumped from \$50 billion, or 6½ percent of the gross national product in 1966, to \$250 billion, or 10 percent of the gross national product, in 1980.

The coalition, Moffitt said, is still fragile at this point. He said he couldn't name which businesses are involved in the effort.

Although the Mississippi State Medical Association has no policing powers, Moffitt said the organization is willing to talk with doctors and try and improve relations between the business and medical communities.

He also hopes more involvement from labor officials and others in the future. Moffitt said the concept has been successful in controlling costs in other areas of the country, such as Philadelphia and Atlanta.

Currently, the organization is studying the business-health insurance situation in Jackson and will soon be working on ways to redesign health care coverage. One change probably will be a greater emphasis on providing preventive and home health care, de-emphasizing hospitalization and high technology, he said.

A survey of 20 Jackson businesses with 100 or more employees shows the greatest concern of Jackson businessmen is increasing health care insurance premiums, he said.

Health care premiums for the 20 firms surveyed were more than \$22 million in 1981.

Although all 20 firms offered some kind of health care coverage, only four offered preventive medical care assistance, such as counseling, nutritional needs and exercise outlets. Moffitt said that is one area that could be improved.

"Inescapably, irrefutably, the enormous health care bill that this nation has could be cut in half if our citizens had healthier lifestyles," he said.

Moffitt made the remarks before about 45 businessmen at the Metro Manufacturers Council meeting sponsored by the Jackson Chamber of Commerce.

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Reprinted from the *Jackson Daily News*, September 22, 1982.

PROFILES

William C. Gates, M.D. Trustee, District 3

When Bill Gates was a young boy in south Alabama, he would frequently catch grasshoppers and frogs to dissect. That early interest in biology, along with the influence of one of his childhood idols, Dr. Aubrey Stabler, a urologist, led him to pursue the study of medicine and eventually to specialize in urology.

He received the B.A. degree from Vanderbilt University and the M.D. degree from the Medical College of Alabama in Birmingham. After interning at Carraway Methodist Hospital in Birmingham, he completed residencies in surgery and urology there and at Brooks Air Force Base in San Antonio, Texas. He has practiced his specialty in Columbus since 1968.

A busy professional life limits the amount of time he can spend pursuing some of his other interests, which include politics, sports, art and music. Although he denies great accomplishments in these areas, the diversity of his hobbies brings to mind the term "Renaissance man."

He is an artist and a member of the American

A karate instructor demonstrates a kick technique to Dr. Bill Gates, left. (Photo courtesy of Columbus Dispatch.)



Physicians Art Association. His favorite medium is water color, although he also enjoys working with charcoal and pastels. Music is another special interest — he plays the piano, guitar, and alto saxophone.

He has what he terms "a voracious appetite for hunting" and particularly enjoys turkey hunting. Another of his primary sports interests is tennis, and he is a regular participant in the MSMA tennis tournament held each year during the Annual Session.

Recently he began to pursue two new interests, calligraphy and karate. He says that occasionally he writes up a chart in calligraphy — and sometimes prescriptions, too — a practice which he says has prompted a lot of calls from pharmacists.

Dr. Gates is studying the Korean form of karate, *tae kwon do*, and currently is pursuing his second belt in this form of the martial arts.

In Columbus, Dr. Gates has been a member of the Columbus Rotary Club and is a member of First Methodist Church, where he has served on the Board of Stewards. He has three children, Currie, a student at Highlands Day School in Birmingham, and Jennie and Bill, III, both students at the University of Alabama.

He is a member of many medical organizations, including the American Urology Association, the American Association of Clinical Urologists, Southern Medical Association, American Medical Association, and the Aerospace Medical Association. He is past president of Loundes County Medical Society, Prairie Medical Society and the Mississippi Urology Society. He is a fellow of the American College of Surgeons and of the American College of Emergency Physicians, and a diplomate of the American Board of Urology. He has served MSMA in many posts, and was elected to the Board of Trustees in 1979, representing District 3.

**Second in a series
featuring members of the
MSMA Board of Trustees**



Dr. Bernard Hunt enjoys spending time on his cattle farm near Grenada.

**W. Bernard Hunt, M.D.
Trustee, District 4**

Although Dr. W. Bernard Hunt has lived in Grenada for thirty years, at various times he has called many different places in north Mississippi "home." He is a native of Abbeville, Mississippi. He is the son of a Methodist minister, and the family lived in a number of north Mississippi towns, moving as his father's pastorates changed.

After serving three years in the Navy, he attended the University of Mississippi, where he received the B.A. and B.S. degrees. He received his M.D. degree from the University of Tennessee School of Medicine at Memphis and interned at Methodist Hospital in Memphis. He established his general practice of medicine in Grenada in 1952.

Dr. Hunt says his interest in medicine may have been stimulated while he was acting as student manager of the high school football team. He recalls that it was during that experience that he had the opportunity "to apply a lot of band-aids" and to observe treatment of injuries.

In 1980 Dr. Hunt was elected to the Mississippi State Medical Association's Board of Trustees, representing District 4. Prior to that time he had compiled a record of service in the MSMA as well as other professional and civic organizations.

He is a charter diplomate of the American Board of Family Practice. He served as president, vice president, secretary-treasurer and member of the Board of Trustees of the Mississippi Academy of Family Practice.

A member of the American Medical Association, Dr. Hunt is also a past president of the North Central Medical Society and of the Grenada Rotary Club. He is past president of the Board of Trustees of Grenada County Hospital.

For ten years Dr. Hunt has served as a member of the Board of Trustees of Kirk Academy. He is a member of the Delta Area Council of Boy Scouts of America and of First United Methodist Church in Grenada.

He is married to the former Betty Crump of Sumner. Their three children and three grandchildren all live in Grenada, which gives the family many opportunities to get together for cookouts and fish-frys.

Dr. Hunt enjoys spending time on his cattle farm in the Grenada area and he has a special interest in hunting, which usually includes a yearly pheasant hunt in Iowa or Nebraska. Whenever he has time, he also enjoys fishing, golf and gardening.



The President Speaking

In Memoriam

SIDNEY O. GRAVES, JR., M.D.
Natchez, Mississippi

Allen Read and his wife Nicky arrived in Natchez in 1953. He became a member of the Natchez Polyclinic, and practiced general medicine until 1961. At that time, he decided to leave the "rat race," and take a residency. Although it was strongly suggested that he was an ideal candidate for internal medicine, he chose pathology. After finishing his residency in pathology at the University of Mississippi Medical Center, he returned to Natchez in 1965 and practiced his specialty until his untimely death on October 14, 1982.

Allen was a good husband and father, a good citizen and a good doctor. He was one of the driving forces in the Community Concert Association. He served on the Board of the Chamber of Commerce, and was active in other civic affairs. He was a member and a long time chairman of the Board of Trustees of the Episcopal Day School. He took a very active interest in his church and served it in many capacities.

He directed Continuing Medical Education at the Jefferson Davis Memorial Hospital. He was highly respected as a pathologist and a physician by his peers. He is probably the only pathologist I have ever known who continued to practice general medicine. There were many people in this area who called on him for medical help, knowing full well that he was not in general practice. To my knowledge, he never turned anyone down.

His funeral was at 2 p.m., October 15, 1982, which was a Friday. I make a point of the time and the day because of the size of the funeral. You don't ordinarily expect a large crowd at a funeral at this time of day, but it was the largest one I have ever attended. A cross section of the community was there to pay their last respects to a good man.

This man's death is a great loss to the community. Certainly, he will be sorely missed by his family and his friends. His stabilizing presence on the medical community of Natchez will be the facet of his personality most difficult to replace. Although he has never held any particularly impressive medical office, either locally or statewide, he was one of our most respected doctors, and he will be remembered that way by those of us who knew him well.

★★★

Our Fees

Are we really worth what we think we are? I have no banks of impressive statistics to back these feelings and I haven't been peeping at your profiles, but this burr has been under my saddle for quite a while. It's all too easy to ascribe the rise in our charges to the spiraling inflation ("everything else is going up") or to the prevalence of third party payors, either private insurance or federal programs ("they're covered"). I think it is high time that we take a good hard look at our "prices."

Realizing that our so-called voluntary cost control program has proved less than a howling success, I cringe at the thought of an involuntary program! As wild as this thought may seem, it hangs on our future's horizon. The interest the insurance companies are manifesting in continued peer review and the federal government's cost-cutting trends are the harbingers. I assure you the astronomical increase in hospital costs is not their only concern. In my private paranoid state I foresee such goodies as physician blacklists, rosters and the like.

What do you say to patients who show you receipts with the inevitable, "Doc, do you know what they charged me?" As per example, \$80 for an office pelvic and Pap smear; \$290 for an office visit with a few scratch tests and a bottle of antigen; \$1,000 for care of bed patient for two weeks and no procedures. You get the drift. I just stand there, look stupid and uneasily say something like, "That is kinda steep!"; thinking of all the classic rationalizations — "You get what you pay for," "It costs more to go first class," etc., etc. Our profession's eroding image can hardly stand another blemish, and "price-gouging" is certainly an ugly word!

ARTHUR A. DERRICK, JR., M.D.
Associate Editor

Medico-Legal Brief

Limit On Attorney's Fees In Suits Not Unconstitutional

A statute limiting attorney's fees in actions against health care providers was constitutional, a California appellate court ruled.

A trial court approved a settlement of \$495,000 for a minor and \$5,000 for his parents in a medical malpractice action. The court also approved attorney's fees of \$90,794.89 for the claimants' attorneys. The attorneys appealed, claiming they had entered into a contingency fee arrangement for 25 percent of the recovery (\$122,820.57). The trial court based the fee award on a statute that limited attorney's fees to 40 percent of the first \$50,000 recovered, 33⅓ percent of the next \$50,000 recovered, 25 percent of the next \$100,000 recovered, and ten percent of any amount over \$200,000. The attorneys argued that the statute was unconstitutional.

Dismissing the appeal, the appellate court said that it would address the merits of the claim because of the significant public interest. The court said that the statute did not impair the right to counsel. Applying the rational relationship test, the court noted that the legislature enacted the statute as part of the remedy to the problem of the breakdown of the health delivery system due to skyrocketing malpractice insurance premiums. The court said the regulation of attorney's fees in malpractice cases was rationally related to the societal issues of malpractice insurance premiums.

The court also noted that attorney's fees were limited in other areas, such as probate and workmen's compensation cases. — *Roa v. Lodi Medical Group, Inc.*, 181 Cal. Rptr. 44 (Cal.Ct. of App., Feb. 26, 1982)

THE LITERATURE

Book Review

Something Hidden: A Biography of Wilder Penfield, by Jefferson Lewis, Garden City, NY: Doubleday and Company, 1981, \$17.95.

As expected, this biography written through the eyes of Dr. Penfield's grandson gives one great insight into Penfield's relationship with his family, colleagues and especially his wife. His time at Princeton and Oxford, England, as a Rhodes Scholar is well portrayed; also discussed is the influence of Osler and Sherrington, the great physiologist, who were no doubt instrumental in directing Penfield into basic research and neurology as part of his neurosurgical training.

Penfield's pioneer work in the area of surgical intervention for epilepsy and his many contributions to the world's literature are well recognized as is his role in the development of one of the world's great neurological institutes in Montreal. One can imagine that he was as aggressive in dealing with his administrative problems as he was with his neurosurgical problem and it would appear that the future has revealed him to be right in most situations.

The book does reveal his many sides, especially those in the later years of life when he, by example, disagreed with his mentor, Osler, on the contributions that individuals over 40 make to society. He was indeed a man for many seasons, having written several novels and biographies; and eventually in his twilight years was a most sought after speaker since he was outspoken on major issues of the day.

The book reads easily and gives great insight into Dr. Penfield, the person, and just enough information about his surgical exploits to realize that he was

Canada's answer to Harvey Cushing. I enjoyed the book and feel many physicians interested in rubbing shoulders with one of the great physicians of our time would do likewise.

WILLIAM C. NICHOLAS, M.D.
Jackson, MS

RECOLLECTIONS

"Polio Immunization: Where Do We Stand?" was the topic of an article in the November 1962 issue of JOURNAL MSMA. The article was an interview with Dr. A. L. Gray, executive officer of the Mississippi State Board of Health and member of the U. S. Public Health Service Special Advisory Committee on Oral Poliomyelitis Vaccine. Dr. Gray responded to questions regarding the conflict between Sabin vaccine and Salk vaccine and the probability of mass immunizations for Mississippi.

Reports of meetings about the state highlighted the news. At a meeting of the Arthritis and Rheumatism Foundation, guest speaker was MSMA president Dr. C. P. Crenshaw, who stressed the importance of informing the American public about the disease condition and the necessity for urging patients to avoid quack remedies and self-medication.

It was reported that Dr. S. G. Mounger had been re-elected president of the Delta Medical Society, and other elected officers included Dr. T. M. Riddell, president-elect and Dr. Howard A. Nelson, secretary-treasurer.

Dr. Guy T. Vise, outgoing president of the Mississippi Academy of General Practice, was pictured with new president Dr. John R. Bane and president-elect Dr. Lawrence H. Brisco, in an article reporting on the academy's 14th annual meeting which was held at the Heidelberg Hotel in Jackson.

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MEDICAL ORGANIZATION

Press Conference Outlines MSMA Drunk Driving Program

The MSMA's statewide campaign to take drunk drivers off the roads, Physicians Against Drunk Drivers (PADD), has received the support of a number of other concerned groups, and a press conference at MSMA headquarters on September 23 outlined the coalition's plan of action.

Part of the program will include the formation of citizens action groups which will: monitor enforcement of the state's DUI laws; encourage legislation to raise the legal drinking age and to eliminate loopholes in the existing laws; and disseminate in local communities public information on the enormity of the problem.

Doris Aiken, national president and founder of RID-USA (Remove Intoxicated Drivers) met with members of the MSMA committee and coalition representatives after telling the press conference, "The citizens of this nation have had it with drunk drivers."

She stressed that part of the RID solution is making sure judges issue maximum sentences under the laws.

That there continues to be an attitude of leniency in the courts is indicated by Mississippi statistics for the first five months of 1982, which reveal that of the 18,000 people ticketed for driving under the influence, only a third have been reported as having been

convicted, and only one third of that third — about 2,000 — have been penalized.

Mrs. Aiken called drunken driving "the most swept-under-the-rug crime in America." She said RID groups are trying to shift the attention of the public to the victims of accidents caused by drunken drivers and to let the public know exactly how serious a crime it is. Drunken drivers are responsible for about half of the fatal traffic accidents yearly; about 26,000 people are killed and 500,000 more are seriously injured each year; drunken drivers are 25 times more likely to have an accident than non-drinking drivers.

Public information to be disseminated by PADD will include a slide presentation which can be shown to local schools or civic groups. Additionally, films on the subject will be available from the State Health Department in Jackson.

Patient Inquiry Program Coordinator Named

The MSMA's new patient inquiry program moved closer to implementation with the hiring of Lora Lane, R.N., as coordinator. Mrs. Lane joined the MSMA staff in September.

The patient inquiry program, established under the direction of the Board of Trustees with the approval of the House of Delegates, is intended to strengthen the association's long-term grievance committee procedures for resolving patients' inquiries about medical services provided by MSMA members. The MSMA Committee on Peer Review will oversee operation of the program under policies established by the Board of Trustees.

Mrs. Lane is a graduate of the Gilfoy School of Nursing, Mississippi Baptist Hospital. She has 20 years' experience in nursing, including psychiatric, long term care, and acute care nursing. For four years she has been associated with the Mississippi Foundation for Medical Care (MFMC). As assistant



Lora Lane, R.N.



Dr. Dewey Lane, chairman of PADD, responds to a reporter's question about the MSMA program to remove drunk drivers from the state's roads. At left is Doris Aiken, president and founder of RID-USA (Remove Intoxicated Drivers), who described the national program during a press conference at MSMA headquarters.

director of the Division of Long Term Care, Mrs. Lane supervised a staff of nurses and social workers in a program of review of long term care patients/facilities for medical necessity, level of care, and quality of care. Prior to joining the staff of MFMC she was associated with the Mississippi Health Care Commission in a program of review of hospitals and long term care facilities.

Mrs. Lane, a Jackson native, is a resident of Clinton. She and her husband, James D. Lane, are the parents of four children.

Dr. David Guyton Presents Ophthalmology Lecture at UMC



Dr. David L. Guyton (center), assistant professor at the Wilmer Ophthalmological Institute, Johns Hopkins University School of Medicine, presented the fourth annual lecture in a series sponsored by the University of Mississippi School of Medicine Department of Surgery Division of Ophthalmology, the Medical Center Division of Continuing Health Professional Education and the Jackson Central Lions Club. With him are participants, from left, Dr. David Segrest of Jackson and Dr. Don Marascalco, UMC resident in ophthalmology.

SBH Approves Revisions In Reportable Diseases Rules

The Mississippi State Department of Health has completed a major revision of its Rules and Regulations Governing Reportable Diseases. The revision was approved by the State Board of Health on April 14, 1982, and is now ready for distribution. Copies are being sent to all physicians in the state," said Dr. Alton B. Cobb, State Health Officer.

The chief purposes of the new edition are to update the material to conform with present knowledge and practice and to simplify the reporting process by reducing the number of disease categories from four to two. This simplification makes process easier by providing more specific information on how it may be accomplished.

Physicians are urged to familiarize themselves with the new Rules and to report those diseases listed in the manner prescribed.

"Your assistance will be appreciated and will greatly facilitate efforts to control communicable diseases in Mississippi," said Dr. W. E. Riecken, State Epidemiologist.

Tighter Regs For Pacemakers Now Appear Likely

Tighter federal reimbursement standards for pacemaker costs appeared likely in the wake of three separate reports charging abuses and over-pricing. All of the reports alleged or cited allegations that pacemakers have been over-prescribed due to high-pressure sales tactics and kickbacks to physicians from salesmen.

The latest report came from the staff of the Senate Aging Committee which concluded that "the necessity or appropriateness" of as much as half the \$2 billion cost of pacemaker procedures to Medicare "can be questioned."

Earlier reports along much the same lines have been issued by the Health Research Group associated with Ralph Nader, and the HHS Department's Inspector General Office. The FBI is conducting an investigation.

At a hearing by the Senate Aging Committee, Whitney McFarlin, Vice President of Pacing Systems Group Medtronic, Inc., a pacemaker manufacturer, defended the pricing system, declaring that "from the earliest years of the industry to the present, pacing has been a cost-effective treatment." He said a recent study of cardiac pacing costs "show that the total cost of treating the pacemaker patient dropped 43 percent from 1965 to 1980."

McFarlin said his company "deplores" questionable sales practices cited in the staff report and welcomes efforts to "bring about reforms in our industry."

The Senate staff study said "the key to the abuses . . . lies in the symbiotic relationship of the physicians and the pacemaker salesman" with "creative marketing devices" to encourage physicians to prescribe pacemakers.

Among such inducements mentioned in the report were stock options for consulting arrangements, payments of up to \$25,000 for "clinical evaluations" of new products, cash payments for each pacemaker implanted, vacations, junkets and gifts.

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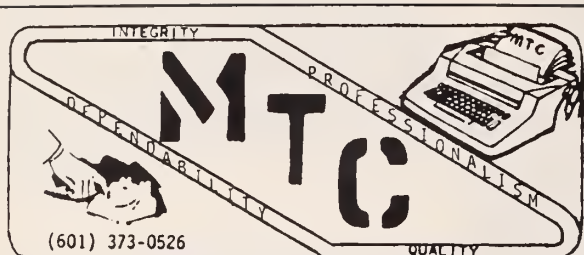
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Review A Book

The following books have been received. Members of MSMA interested in reviewing any of these volumes should address their requests to Editor, JOURNAL MSMA, P.O. Box 5229, Jackson, MS 39216. After submitting to the JOURNAL a review for publication, you may keep the books for your personal libraries.

Physician's Handbook: Twentieth Edition. Los Altos: Lange Medical Publications, 1982. \$12.00.

Current Medical Diagnosis & Treatment. Edited by Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. Los Altos: Lange Medical Publications, 1982. \$26.00.

Review of Medical Microbiology: Fifteenth Edition. Los Altos: Lange Medical Publications, 1982. \$17.00.

Current Pediatric Diagnosis & Treatment: Seventh Edition. Los Altos: Lange Medical Publication, 1982. \$26.00.

Basic & Clinical Immunology: Fourth Edition. Los Altos: Lange Medical Publications, 1982. \$22.00.

Current Obstetric & Gynecologic Diagnosis & Treatment: Fourth Edition. Edited by Ralph C. Benson, M.D. Los Altos: Lange Medical Publications, 1982. \$25.00.

Principles of Clinical Electrocardiography: Eleventh Edition. Edited by M. J. Goldman, M.D. Los Altos: Lange Medical Publications, 1982. \$15.00.

At some time each of us will probably visit the country doctor's office at the Agriculture Museum. To date it is not funded. I realize that we are besieged daily for contributions to some cause or other, but we alone are responsible for this particular project. If each physician would contribute only \$20, our funding problem would be over. Please help. You'll be glad you did when you see it. — W.M.D.

POSTGRADUATE CALENDAR

Dec. 2, 1982

THE HEALING DIALOGUE

University Medical Center, Jackson

Sponsored by the University Hospital Department of Pastoral Services and the University of Mississippi Medical Center Division of Continuing Health Professional Education.

Coordinator: James L. Travis, Ph.D., director of pastoral services, University Hospital.

Dr. James J. Lynch, professor of psychiatry and co-director of the Psychophysiological Clinic at the University of Maryland School of Medicine, is guest speaker. He is author of the book, *The Broken Heart: The Medical Consequences of Loneliness*. Participants will look at the links between communication, health and stress-induced illness. Fee: \$25. Credit: 5 contact hours (.5 CEU).

Dec. 9-10, 1982

PERINATAL POSTGRADUATE COURSE

Holiday Inn Downtown, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Obstetrics and Gynecology Division of Maternal-Fetal Medicine, the Department of Pediatrics Division of Newborn Medicine, the School of Nursing and the Medical Center Division of Continuing Health Professional Education.

Coordinators: John Morrison, M.D., professor of obstetrics and gynecology and director of the division of maternal-fetal medicine, and Philip G. Rhodes, M.D., associate professor of pediatrics and chief of the division of newborn medicine.

This course will focus on the diagnosis and management of the high risk parturient and neonate. Ethical issues in the care of the seriously ill and genetic counseling will be covered. High risk areas such as prematurity and chronic hypertension in the mother and infection and metabolic disturbances in the neonate will be included. Fee and credit to be announced.

FUTURE CALENDAR

March 10-12, 1983

SURGICAL FORUM X

Holiday Inn Downtown

NOVEMBER 1982

March 17-18, 1983

MEDICINE IN THE OLD SOUTH

University Medical Center, Jackson

March 26, 1983

PHOTOGRAPHY UPDATE FOR EDUCATION AND SLIDE PROGRAMS

Keesler Air Force Base, Biloxi

For more information on continuing education, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone: (601) 987-4914.

NEW MEMBERS

ARLINGTON, ALAN H., Pascagoula. Born Jackson, MS, Feb. 10, 1951; M.D., University of Alabama School of Medicine, Birmingham, 1975; interned University of California Davis Medical School, Los Angeles County, one year; residency (medicine), same, Martinez, CA, 1977-79; residency (medicine) Tulane University, New Orleans, 1979-1981; elected by Coast Counties Medical Society.

COOPER, TOM S., Clarksdale. Born Memphis, TN, March 31, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned Baptist Hospital, Memphis, one year; residency (ophthalmology) University of Tennessee, Memphis, 1973-76; elected by Clarksdale & Six Counties Medical Society.

FIALKOW, ROBERT Z., Greenville. Born Brooklyn, NY, Jan. 12, 1947; M.D., State University of New York at Buffalo School of Medicine, 1972; interned Medical College of Georgia, Augusta, one year; residency (medicine) Wadsworth V. A. and UCLA, Los Angeles, 1973-74; residency (medicine) Baylor College of Medicine, Houston, 1974-75; residency (nephrology) University of Arizona Health Sciences Center, Tucson, 1976-78; elected by Delta Medical Society.

WESTBROOK, DAVID O.: Jackson. Born Little Rock, AR, June 21, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned University Medical Center, Jackson, one year; residency (medicine) same, 1977-79; residency (pulmonary) same, 1979-81; elected by Central Medical Society.

PERSONALS

A. W. CONERLY of UMC was a keynote speaker for the annual meeting of the South Carolina Society of the American Association of Respiratory Therapy in Greenville, South Carolina, in September, and also attended a meeting in Salt Lake City of the National Board of Respiratory Therapy.

EDGAR DRAPER of UMC recently presented a seminar at the VA Medical Center in Big Spring, Texas.

JAMES HARDY of UMC recently presented a paper and chaired a session of the International Surgical Groups in London, attended a meeting of the executive committee of the International Society of Surgery as editor of the *World Journal of Surgery* in Basel, Switzerland, and attended the annual congress of the French Association of Surgeons.

RICHARD HUTCHINSON of UMC recently served as a consultant to the National Heart, Lung and Blood Institute research review committee in Bethesda, Maryland.

HERBERT LANGFORD of UMC recently spoke at the Western Pennsylvania Hospital in Pittsburgh and

participated in a nutrition and blood pressure control symposium in Arlington, Virginia.

REEDA LYONS announces the opening of an office for the practice of pediatrics at the Ellis Building in New Albany.

KANWAL NAIN MANIKTAHLA of Batesville was named a fellow of the International College of Surgeons at the convocation in Atlantic City, New Jersey, in September.

WILLIAM W. MAYER has associated with Laurel Urology Clinic, P.A., for the practice of urology.

EDMUND MILLER, JR. announces the opening of his office for the practice of internal medicine at 217 West Broad Street in West Point.

ELLIS MOFFITT, MSMA Board of Trustees chairman, spoke at the Metro Manufacturers Council in Jackson on the subject of "Health Care Coalitions — A Means for Controlling Health Care Costs."

JOHN MORRISON of UMC was guest speaker of the perinatal division of Ochsner Foundation Hospital in New Orleans, presented a paper at a meeting of the American Chemical Society in Kansas City, and was guest speaker at a meeting of the Nursing Association of the American College of Obstetricians and Gynecologists in Chicago.

KAMLESH D. NAYAK announces the opening of his office for the practice of adult cardiology and internal medicine at 1203 Jefferson Street in Laurel.

DAVID REEVES announces the opening of his office for the practice of pediatrics at 515A LaRosa Road in Long Beach.

ROBERT SMITH of UMC gave a seminar during a symposium on cerebrovascular disease in Scranton, Pennsylvania.

MALCOLM P. TAYLOR and T. B. ELLIS, III, announce the opening of their office for the practice of cardiology at 1011 Mission 66, in Vicksburg.

MARION D. TUCKER announces the opening of an office for the practice of pediatrics at No. 3 Marks Road in Ocean Springs.

GUY T. VISE, JR., of Jackson was installed as Chairman of the Council of Southern Medical Association at the SMA's 76th Annual Scientific Assembly in Atlanta.

W. LAMAR WEEMS of Jackson was visiting professor at the Memorial Medical Center in Savannah, Georgia.

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References:

1. Hart FD, Huskisson EC, Ansell BM in Hart FD (editor): Drug Treatment of the Rheumatic Diseases, 2nd Ed, Adis Press, Balgowlah, Australia, 1982, p. 30.
2. Rondeau PL, Yeung E, Nelson P: Canad Dent Assoc J 46:433-439, 1980.
3. Selwyn P and Giles AD: Br Jrl of Clin Practice, Supplement 6, Safe and effective analgesia following dental surgery: A comparison of brufen and distalgesc. Pg 87-90, 1980.
4. Taina E: Curr Med Res Opinion, 7:423-428, 1981.

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CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angio-edema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see WARNINGS).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally; however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination. Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: Coumarin-type anticoagulants. The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin. Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS: Incidence greater than 1%. **Gastrointestinal:** The most frequent adverse reaction is gastrointestinal (4 to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS). Incidence 3% to 9%.

Incidence less than 1 in 100. Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome and alopecia. **Special Senses:** hearing loss, amblyopia (blurred and/or diminished vision, scotomata and/or changes in color vision) (see PRECAUTIONS). **Hematologic:** neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura eosinophilia, decreases in hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Allergic:** syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasms (see CONTRAINDICATIONS). **Renal:** acute renal failure in patients with preexisting significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria. **Miscellaneous:** dry eyes and mouth, gingival ulcers, rhinitis.

Causal relationship unknown. Gastrointestinal: pancreatitis. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri. **Dermatologic:** toxic epidermal necrolysis, photoallergic skin reactions. **Special Senses:** conjunctivitis, diplopia, optic neuritis. **Hematologic:** bleeding episodes. **Allergic:** serum sickness, lupus erythematosus syndrome, Henoch-Schönlein vasculitis. **Endocrine:** gynecomastia, hypoglycemia. **Cardiovascular:** arrhythmias (sinus tachycardia, bradycardia, and palpitations). **Renal:** renal papillary necrosis.

OVERDOSSAGE: Acute overdosage should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

DOSE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flareups of chronic disease: Suggested dosage 400 mg t.i.d. or q.i.d.

Dysmenorrhea: 400 mg every 4 hours as necessary

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for the relief of pain. Do not exceed 2,400 mg per day.

CAUTION: Federal law prohibits dispensing without prescription.

MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 19-23, 1983, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610

State and Local

Mississippi State Medical Association, 115th Annual Session, May 11-15, 1983, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, July 6-9, 1983, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39221.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 3rd Wednesday, January, May, and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. J. Barry Gilbert, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Robert L. Coggin, Pres. and Secy., 965 Avent Dr., Grenada 38901. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, State, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March,

June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River. Prairie Medical Society, 2nd Tuesday, March, June, September, December. Albert H. Laws, Secy., 816 Second Ave. North, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubec.

Singing River Medical Society, 3rd Monday, January, March, June, September, December. Robert D. Holbert, Secy., P.O. Box 1502, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Douglas F. Thomas, Secy., 415 South 28th Ave., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly
Mississippi State Medical Association
735 Riverside Drive
Jackson, MS 39216

North Mississippi Medical Center
830 Gloster Avenue
Tupelo, MS 38801

Forrest General Hospital
Box 1897
Hattiesburg, MS 39401

Mississippi Baptist Hospital
1225 N. State Street
Jackson, MS 39201

Gulf Coast Community/Gulfport
Memorial Hospital Consortium
4642 W. Beach Boulevard
Biloxi, MS 39531

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Delta Medical Center
Greenville, MS 38701

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Biloxi Regional Medical Center
1559 Lafayette St.
Biloxi, MS 39533

Mississippi Radiological Society
316 Medical Arts Building
Jackson, MS 39201

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

Mercy Regional Medical Center
100 McAuley Drive
Vicksburg, MS 39180

North Panola County Hospital
Drawer 160
Sardis, MS 38666

Singing River Hospital
2809 Denny Avenue
Pascagoula, MS 39567

Magnolia Hospital
Alcorn Drive
Corinth, MS 38834

Greenwood Leflore Hospital
1508 Leflore Avenue
Greenwood, MS 38930

South Washington County Hospital
Drawer 398
Hollandale, MS 38748

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FAMILY PRACTITIONERS. Excellent private practice opportunity, well equipped 30-bed hospital in operation less than two years. Office space available in renovated clinic, 100-bed nursing home, nice community, good schools and recreational facilities, located 30 miles east of Jackson. Call (601) 732-6252 or write A. B. Farris, Jr., Mayor, P. O. Drawer 338, Morton, MS 39117.

NOTICE

INTERNS, RESIDENTS, ANY PHYSICIAN LICENSED TO PRACTICE MEDICINE IN MISSISSIPPI

Positions for part-time medical consultants are now available at the Disability Determination Services of Mississippi. The pay and hours are good. Interns and residents wanting to interrupt their training programs for a year or more are welcome to apply. If interested, call 922-6811, ext. 2277 (Dr. John Barr) or ext. 2000 (Mr. John Cook).

Situations Wanted

HEMATOLOGIST-ONCOLOGIST seeks associate or solo practice. Contact Thomas Twele, M.D., 272 Shadow Mountain, El Paso, TX 79912.

PHYSICIAN completing pathology residency in September 1982 seeks location with pathology group with emphasis on surgical pathology. Graduate of University of Tennessee School of Medicine. Contact Dr. William D. Crump, 1027-B Beacon Parkway East, Birmingham, AL 35209.

FAMILY PRACTICE resident seeks practice location in July 1983. Contact John D. Sites, M.D., 2002 Philip Dr., Muncie, IN 47302.

ANESTHESIOLOGIST seeks to relocate in state in solo, group or institutional practice. Contact M. T. Olivo, Jr., M.D., Box 794, Oxford, MS 38655.

BOARD ELIGIBLE PATHOLOGIST seeks practice opportunity. Graduate of University of Mississippi School of Medicine; residencies, UMC. Contact Marianna G. Pardue, M.D., 315 Cedarwood, Jackson, MS, 39212.

BOARD CERTIFIED FAMILY PRACTITIONER seeks practice location. Currently completing military obligation and available 7/82. Contact John E. Bailes, Jr., M.D., 5405 Hackney Circle, Bossier City, LA 71111.

OCCUPATIONAL HEALTH physician seeks position in industry or similar position. M.D. from University of Miami, 1962. Residency in internal medicine at Erlanger Hospital, Chattanooga, and at UMC, Jackson. Contact: Gary LeBow, M.D., 202 Vail Avenue, #218, Homewood, AL 35209; (205) 942-0993.

SURGEON seeks location with established group in small city. Currently service as chief surgical resident at Ochsner Foundation Hospital. Available July 1983. Contact Thomas C. Kelly, M.D., 1516 Jefferson Highway, New Orleans, LA 70121.

PATHOLOGIST-ONCOLOGIST seeks practice location. Frank P. Urso, M.D., P. O. Box 1149, Akron, OH 44301.

CLASSIFIED

CHIEF MEDICAL OFFICER for Department of Corrections in Missouri. Administrative work combined with medical duties. Stable employment in a middle class city. Immediate opening. Contact: Melvin Gardner, Personnel Officer, P.O. Box 236, Jefferson City, MO 65102.

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GENERAL SURGEON AND INTERNIST NEEDED. Rural, well-equipped, 50-bed hospital in Northeast Mississippi. Recently renovated. Offers fantastic opportunity for board certified or board eligible physician. Call or write Carson Wood, Administrator, Community Hospital of Calhoun County (601) 983-4321, P.O. Box 128, Pittsboro, MS 38951. (Other locations may be available.) A U.S. Health Corporation hospital.

SEEKING MEDICAL OFFICE MANAGEMENT position; 12 years working experience, all phases of office management, complete with accounting, taxes, insurance and other vital skills valuable to your corporation. Call 932-1682, Ms. Bullard.

115th Annual Session

May 11-15, 1983 Royal D'Iberville Hotel, Biloxi

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IN CONCLUSION

Physicians across the country are being alerted by the AMA to watch for signs of adverse effects in certain patients exposed to a chemical contaminant of Agent Orange known as TCDD. The alert is in a report published in the October 15 issue of JAMA. It is based on a review by the AMA Council on Scientific Affairs of the medical evidence on toxicity and long-term health effects of Agent Orange. Chemicals of Agent Orange have been used extensively by homeowners and farmers, but the report does not estimate the total number of people exposed in that manner.

A computerized information network for the medical profession was launched last month by the AMA and GTE Corp. The network will feature four data bases that are licensed and maintained by the AMA: Drug Information, Disease Information, Socio-Economic Bibliographic Information, and Medical Procedure Coding and Nomenclature. Eventually, physicians and other users at computer terminals will have instant access to medical information and protocols, along with a broad range of other information. The program is now undergoing field trials.

A combination of powerful drugs has been remarkably successful under experimental circumstances in controlling severe rheumatoid arthritis in a small group of patients, according to a report in the October 8 issue of JAMA. In an accompanying editorial, the results were labeled "a remarkable feat," but cautioned that the treatment requires careful supervision and documentation and called for restraint in its use. The study involved 17 patients, of whom 14 improved, some to the point that they no longer needed any medication, even aspirin.

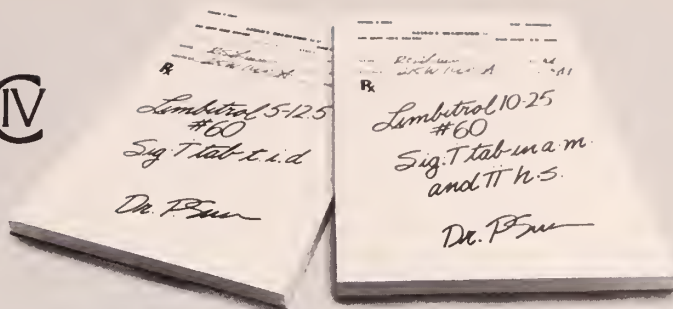
Progress is being made in the American Academy of Pediatrics campaign to attain health insurance coverage of preventive care for children, reports the AAP's newsletter. In addition to meetings with labor union representatives on collectively-bargained plans, an economist/consultant to the academy recently prepared and distributed to 4,400 union publications a series of articles on the value of preventive child health care and the need for improved health insurance coverage. The AAP has allied with the Rand Corporation to seek information on child health care utilization and costs.

Florida has become the seventh state to enact a law creating a health insurance risk pool to provide insurance coverage for persons who have had difficulty obtaining health insurance coverage. Commercial insurers and nonprofit health care services plans are required to participate in the program, called "State Comprehensive Health Association." Participants are to be assessed for any deficits incurred by the Association; such assessments may be offset against state corporate income tax. The law requires policies sold through the association to be available July 1, 1983.

Limbitrol®

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)

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In anxious depression,

SPECIFIC FOR THE NONPSYCHOTIC PATIENT

Fits the picture of anxiety/depression correlation

Most patients with a mood disorder have a mixture of anxiety and depression. One clinician¹ found a correlation of 0.7 in anxiety and depression scores; another² has estimated that 7 of 10 nonpsychotic depressed patients are also anxious. For the dual symptomatology of anxious depression, Limbitrol provides dual medication.

More appropriate for the nonpsychotic depressed and anxious patient

Limbitrol contains both amitriptyline, specific for symptoms of depression, and a benzodiazepine, specific for the symptoms of anxiety. Thus it is a better choice than other dual agents for anxious depression that contain a phenothiazine, a class of antipsychotic drugs less specific for anxiety and now generally avoided in nonpsychotic patients.^{2,3}

Avoids the risk of tardive dyskinesia carried by the phenothiazine combinations

The causal relationship between the phenothiazines and other extrapyramidal side effects, including tardive dyskinesia, is well established. In contrast, the reported incidence of these adverse reactions with Limbitrol or either of its components is rare.

References: 1. Cloghorm J: *Psychosomatics* 11:438-441, Sept-Oct 1970. 2. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, edited by Jarvik ME. New York, Appleton-Century-Crofts, 1977, p 316. 3. Boldessarini RJ, Torsy D: Tardive dyskinesia, in *Psychopharmacology: A Generation of Progress*, edited by Lipton MA, DiMascio A, Killam KF. New York, Raven Press, 1978, p 999.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of

suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, over sedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely. The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs. **Cardiovascular:** Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. **Psychiatric:** Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomit-

ing, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

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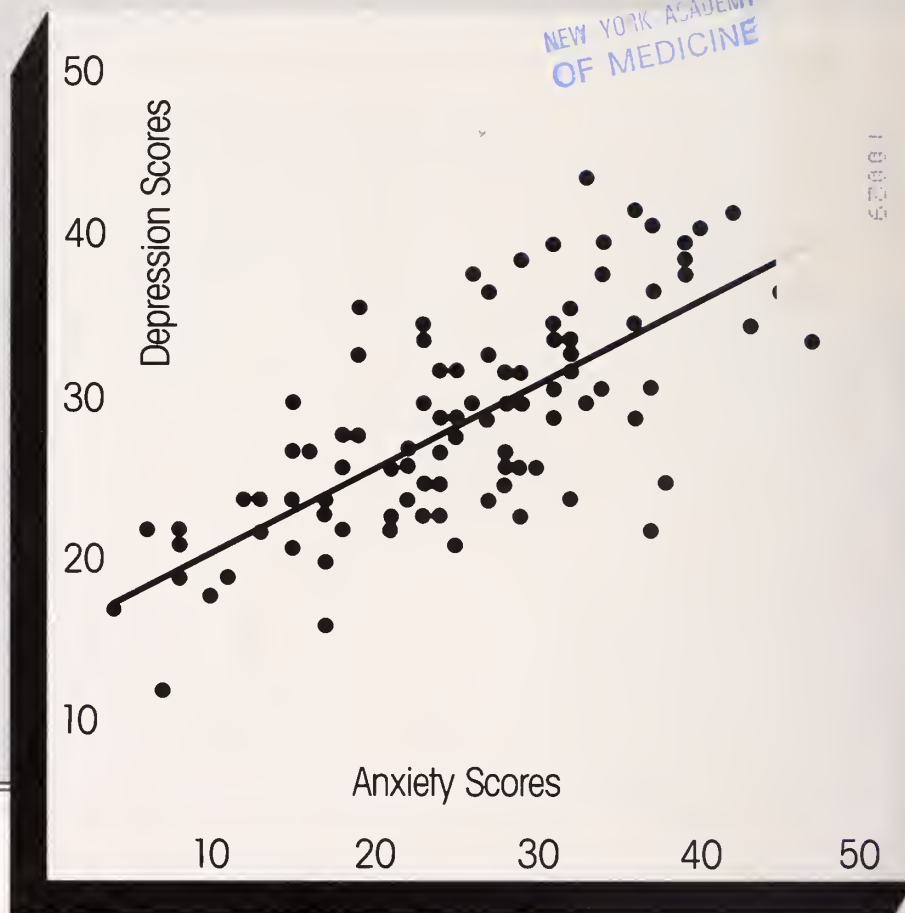
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1982

The graph illustrates the close correlation between depression and anxiety derived through the MMPI and the Taylor Manifest Anxiety Scale in 100 nonpsychotic psychiatric patients. The Coefficient of Correlation is 0.7. As depression increased, so did the anxiety levels.

—Adapted from Claghorn J¹



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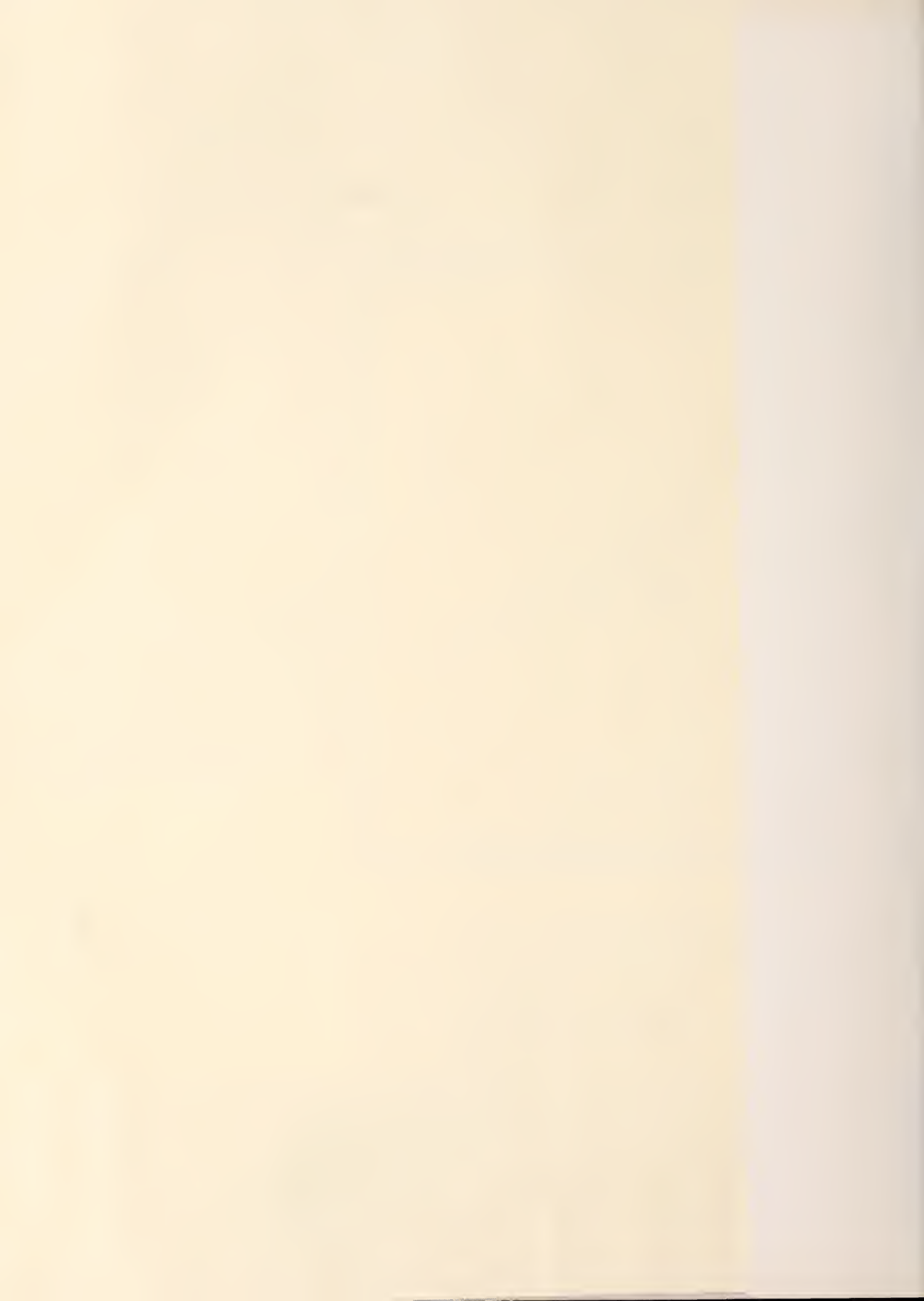
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1. Claghorn J. *Psychosomatics* 11:438-441, Sept-Oct 1970

Please see summary of product information on inside cover



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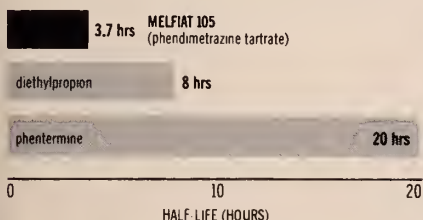
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MELFIAT 105 (phendimetrazine tartrate), an effective anorexiant, provides the appetite control overweight patients often need to begin a successful program of weight reduction. And the positive results of initial short-term therapy with MELFIAT 105 can help motivate them to a lifelong commitment of weight control.

Because MELFIAT 105 has a 3.7 hour half-life and low abuse potential.

Therapeutic efficacy combined with a short half-life and minimal abuse potential make MELFIAT 105 the drug of choice in the treatment of exogenous obesity. Because MELFIAT 105 has a short half-life, it minimizes drug accumulation and helps to eliminate such effects as disturbed sleep patterns. And, because MELFIAT 105 has significantly lower abuse potential than the amphetamines; there's less risk to your patients. According to a NIDA (National Institute on Drug Abuse) report, phendimetrazine appears to be the least abused anorexiant when compared to phentermine and diethylpropion!

Half-life comparison of MELFIAT 105 and other anorexiant²



MELFIAT® 105 UNICELLES® C^{III}

(phendimetrazine tartrate)
Sustained-Release Capsules 105 mg

Because MELFIAT 105 is in a sustained-release capsule.

MELFIAT 105 provides your patients with continuous drug delivery for appetite control that lasts throughout the day and helps to eliminate compulsive snacking and overeating at meals. In addition, the sustained-release capsule form maintains more constant blood levels of MELFIAT 105... without peaks and valleys.

Because MELFIAT 105 offers convenient, once-a-day dosage.

MELFIAT 105 is available in a convenient capsule containing 105 mg. The simple morning dosage regimen is designed to encourage compliance, minimizing the chance of missed doses and assuring optimum therapeutic results.

Because MELFIAT 105 is from Reid-Provident Laboratories, Inc.

Reid-Provident has the highest standards of quality to assure that only the finest products reach you. An advisory board of research scientists, physicians, pharmacists, and other technical staff continually review existing products and new product proposals to make sure that the latest pharmaceutical technology is used in their design and manufacture. That's because Reid-Provident is committed to you and your patients.

For more information please write to Reid-Provident Laboratories, Inc.
640 Tenth Street, N.W.
Atlanta, Georgia 30318

References: 1. Sheu YS, Ferguson JA, Cooper JR: *Evaluation of the Abuse Liability of Diethylpropion, Phendimetrazine, and Phentermine*, unclassified document ADAMHA, HHS, Office of Medical and Professional Affairs, NIDA, 1980.
2. Douglas JG, Munro JF: The role of drugs in the treatment of obesity, *Drugs* 21:362-373, 1981.

MELFIAT® 105 UNICELLES® C

(phendimetrazine tartrate) 105 mg Sustained-Release Capsules

INDICATIONS AND USAGE: Melfiat® 105 (phendimetrazine tartrate) is indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class (See CLINICAL PHARMACOLOGY) should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines; glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result).

WARNINGS: Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should be discontinued. Phendimetrazine tartrate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

Drug Dependence: Phendimetrazine tartrate is related chemically and pharmacologically to the amphetamines. Amphetamines and related stimulant drugs have been extensively abused, and the possibility of abuse of phendimetrazine tartrate should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with intense psychological dependence and severe social dysfunction. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high-dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG, manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia.

USAGE IN PREGNANCY: The safety of phendimetrazine tartrate in pregnancy and lactation has not been established. Therefore, phendimetrazine tartrate should not be taken by women who are or may become pregnant.

USAGE IN CHILDREN: Phendimetrazine tartrate is not recommended for use in children under 12 years of age.

PRECAUTION: Caution is to be exercised in prescribing phendimetrazine tartrate for patients with even mild hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of phendimetrazine tartrate and the concomitant dietary regimen. Phendimetrazine tartrate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdose.

ADVERSE REACTIONS: Cardiovascular: Palpitation, tachycardia, elevation of blood pressure.

Central Nervous System: Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache; rarely psychotic episodes at recommended doses.

Gastrointestinal: Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances.

Allergic: Urticaria.

Endocrine: Impotence, changes in libido.

OVERDOSAGE: Manifestations of acute overdose with phendimetrazine tartrate include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states.

Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma. Management of acute phendimetrazine tartrate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Acidification of the urine increases phendimetrazine tartrate excretion. Intravenous phentolamine (Regitine) has been suggested for possible acute, severe hypertension, if this complicates phendimetrazine tartrate overdose.

DOSAGE AND ADMINISTRATION: Since Melfiat® 105 (phendimetrazine tartrate) 105 mg is a sustained-release dosage form, limit to one sustained-release capsule in the morning. Melfiat® 105 (phendimetrazine tartrate) is not recommended for use in children under 12 years of age.

HOW SUPPLIED: Each orange and clear sustained-release capsule contains 105 mg phendimetrazine tartrate in bottles of 100.

CAUTION: Federal law prohibits dispensing without prescription.

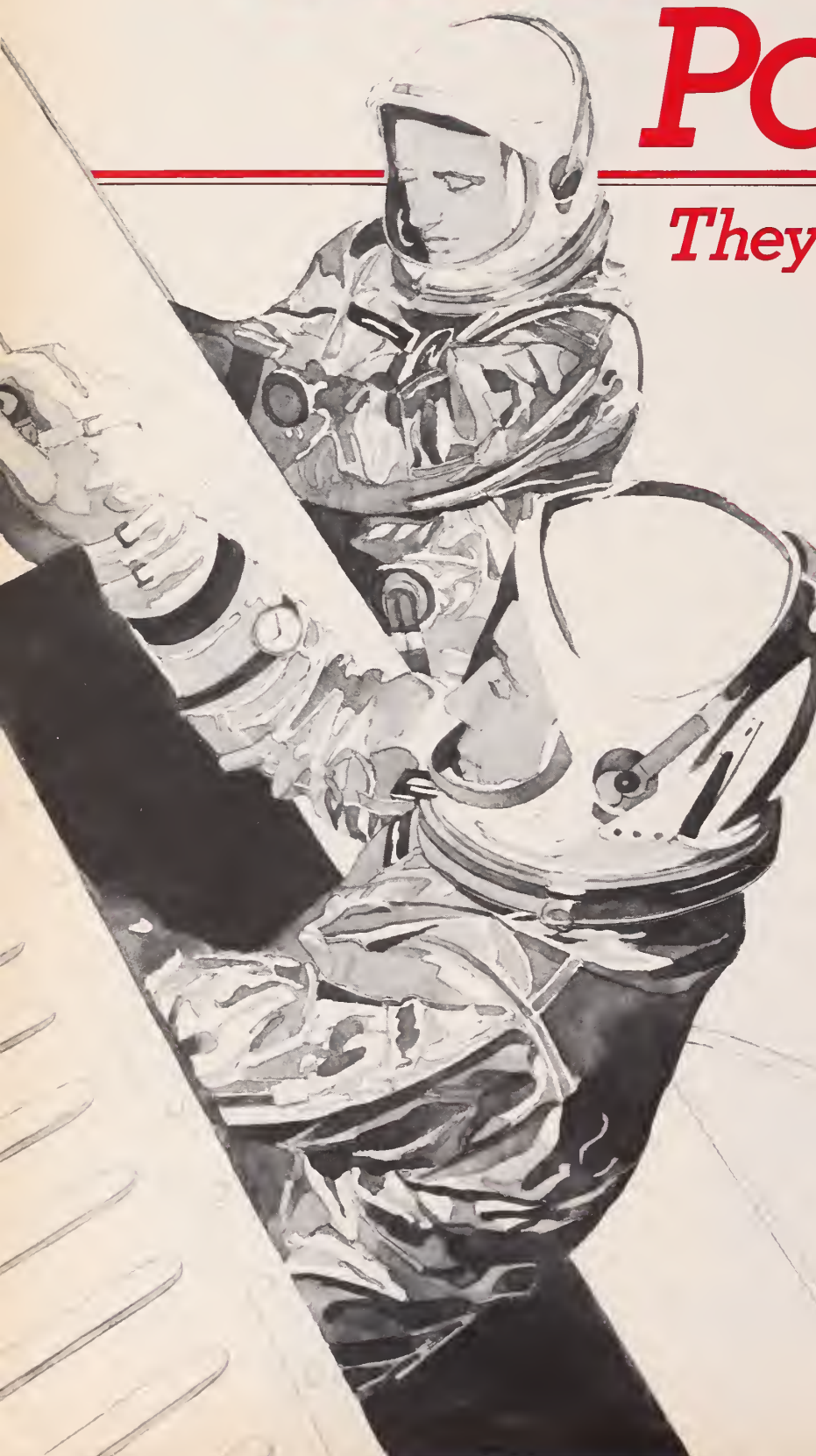


Reid-Provident Laboratories, Inc.
Atlanta, Georgia 30318

Famous Pairs.

*They work so
well together.*

One of man's most amazing explorations and scientific adventures, the successful Gemini flight program was a triumph of imagination and—teamwork. Two men learned to operate in space, to rendezvous, to dock, and to work outside their spacecraft in the hard vacuum of outer space. Not only did they coordinate their efforts with ground backup, they also complemented each other's activities within the close confines of the space capsule.



Anusol-HC[®] & Tucks[®]

...another well-known pair that works so well together! Ninety-five percent of colon/rectal surgeons surveyed* added Tucks pads concomitantly to hemorrhoidal treatment programs they recommended.



Anusol-HC[®] Suppositories/Cream with Hydrocortisone Acetate

The #1 physician-prescribed product for hemorrhoids and other common anorectal disorders**

- ☐ Antiinflammatory, to relieve edema, burning, itching, pain
- ☐ Astringent, to help promote healing
- ☐ Emollient, for easier bowel movements and soothing relief of local trauma

And, when pain is a special problem, Anusol Ointment offers the benefits of the anesthetic, pramoxine HCl.

TUCKS[®]

Pre-Moistened Hemorrhoidal/Vaginal Pads

The #1 hemorrhoidal pad* for added external relief and gentle cleansing of fecal residue

- ☐ Soothes, cools, comforts the irritation and itch of hemorrhoids and other common anorectal disorders
- ☐ Hygienic rectal wipe—an integral part of the anorectal regimen

Once pain and inflammation subside, for dual action recommend regular ANUSOL[®]—to maintain patient comfort—and TUCKS[®]—to maintain patient anorectal hygiene.

PARKE-DAVIS

Warner-Lambert Company
Morris Plains, NJ 07950

**WARNER
LAMBERT**

* Meeting of Am Soc Colon/Rectal Surgeons, May 1980.

** Based on total prescriptions filled for hemorrhoidal preparations during the first three quarters of 1981. The National Prescription Audit, IMS America Ltd, Sept 1981.

* 1981 data from leading marketing research organization.

ANUSOL-HC[®] Suppositories/ ANUSOL-HC[®] Cream

Before prescribing, please see full prescribing information. A Brief Summary follows:

Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in external and internal hemorrhoids, proctitis, papillitis, cryptitis, and fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol[®] Suppositories or Ointment.

CONTRAINDICATIONS

Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

WARNINGS

The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

PRECAUTIONS

General

Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.

Pregnancy

See "WARNINGS"

Pediatric Use

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

DOSE AND ADMINISTRATION

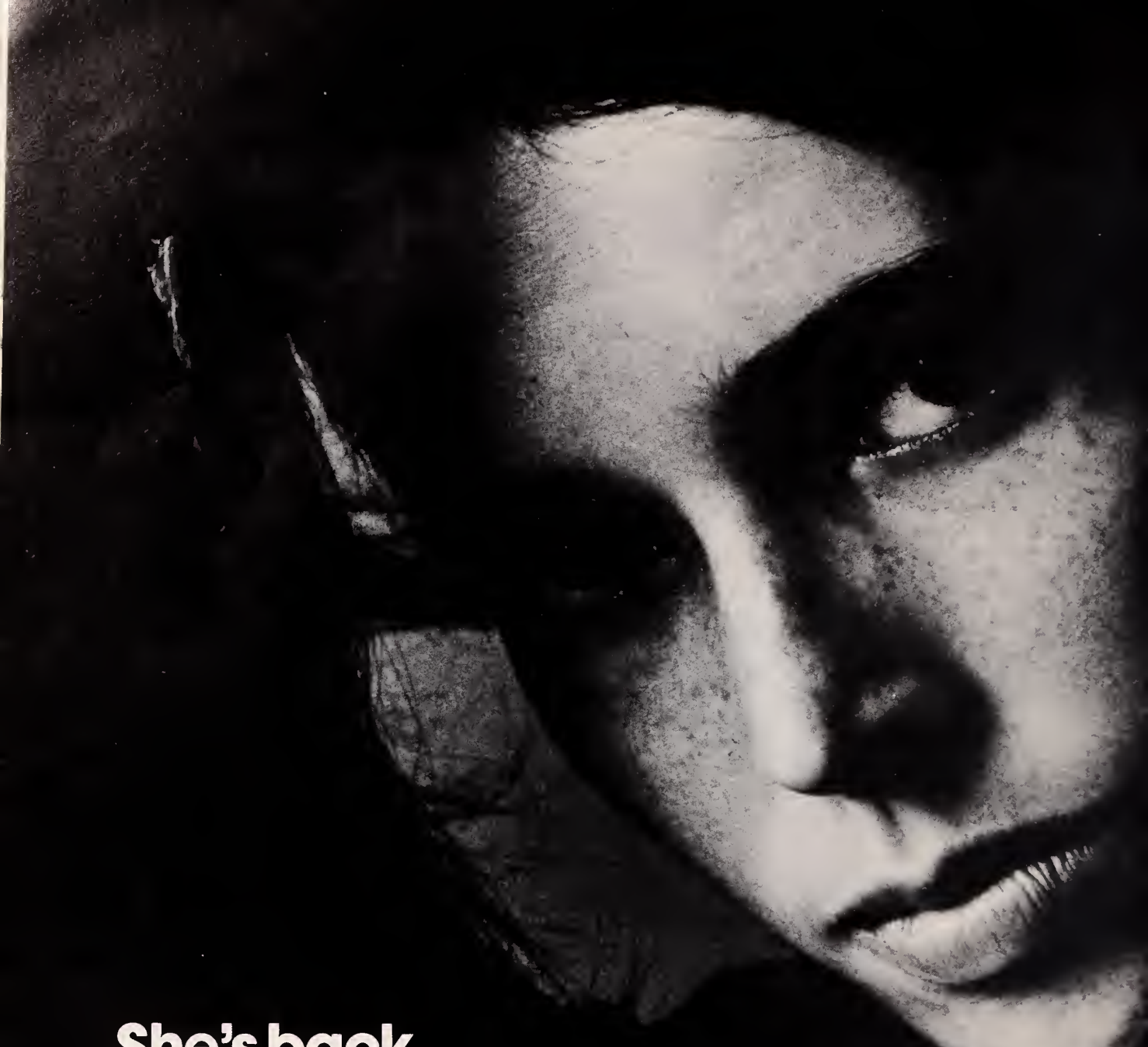
Anusol-HC Suppositories—Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

Store between 59°-86°F (15°-30°C)

1089G010



She's back. How can you help her this time?

Many patients presented with physical symptoms are suffering from psychiatric illness, but are unaware of it. And while not all who suffer from mental illness or emotional problems need hospital treatment, hospitalization may be essential to provide a therapeutic environment in which the patient can effectively deal with his or her problems.

Riverside Hospital is a 56-bed, short-term care facility which provides intensive treatment of patients suffering from psychiatric illnesses, alcoholism, and drug dependencies. In Riverside's open, non-institutional environment, traditional and new, progressive psychotherapies are utilized.

Above all, care at Riverside is aimed at treating the patient with respect and dignity, fostering self-esteem, and returning the patient to independence and a satisfying, productive and happy life.

Riverside is licensed by the Mississippi Commission on Hospital Care, and is fully accredited by the Joint Commission on Accreditation of Hospitals.

The medical staff includes a large number of psychiatrists in private practice in the Jackson area. A toll-free number, 1-800-962-2180, has been established at the hospital for referral service to physicians on the active medical staff.

Physicians who have patients who would benefit from the type of treatment approach offered by Riverside may obtain referral information by contacting the Director of Admissions.

 **Riverside Hospital**

P. O. Box 4297, Jackson, Mississippi 39216

Telephone: (601) 939-9030

Incoming Mississippi WATS: 800-962-2180

NEWSLETTER

December 1982

Dear Doctor:

Concern about medical costs is increasing among physicians and the general public alike, according to an AMA survey. In 1,000 telephone interviews with randomly selected physicians, 58% said they considered cost to be the main problem facing medicine today. Of public respondents, 62% said the main problem is cost. Last year, 55% of the public respondents replied that cost was the primary problem.

Nearly half (47%) of the American people believe that not enough of society's resources are being directed to health care, the survey found. Health care, however, is not the public's highest priority when it comes to spending more money. Education, the environment, and aid to the poor received higher ratings.

The FDA has announced deadlines for putting over-the-counter drugs in tamper-resistant packages. The most vulnerable drugs, such as capsules and liquids, must be in such packaging by Feb. 5. All products not in compliance must be off the shelves by the same date in 1984. Estimates of the cost to consumers for the packaging vary from one or two cents to ten cents a package.

Alcoholism is on the increase, according to a recent Gallup poll. One in three Americans said alcoholism has been a problem in their families, the largest number to give that response since the question was first asked by Gallup in the 1940s. The previous high was in 1978, when 24% of those polled said alcoholism had troubled their family.

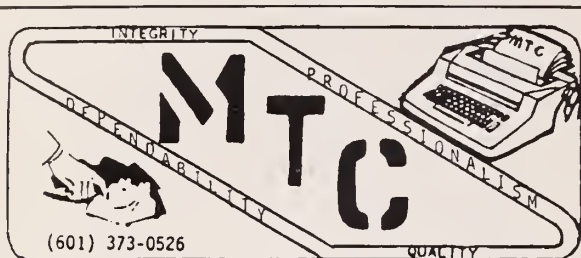
Prescription drugs dispensed by physicians are subject to child protection packaging standards of the Poison Protection Packaging Act, just as are drugs dispensed by pharmacists, the Consumer Products Safety Commission told the Oregon Medical Assn. Physicians may make exception for elderly and handicapped people unable to use child-resistant packaging, the CPSC ruled.

The staff and officers of the Mississippi State Medical Association wish for all members and their families a most joyous holiday season and a happy and healthy year in 1983. During the holiday season and always, "May you have the spirit of Christmas, which is Peace; the gladness of Christmas, which is Hope; the heart of Christmas, which is Love."

Sincerely,



Patsy Silver
Managing Editor



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about helping patients
understand their
prescription medication...

with your help,
Roche has been doing
something about it



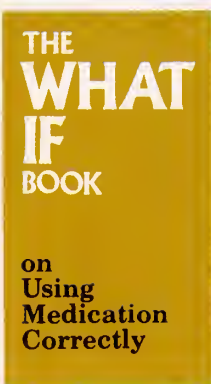
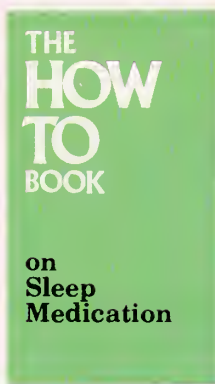
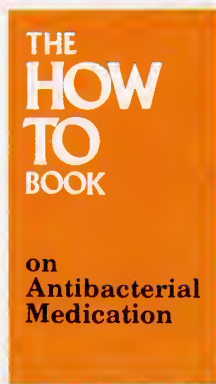
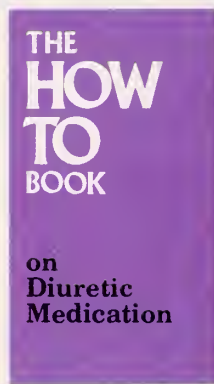
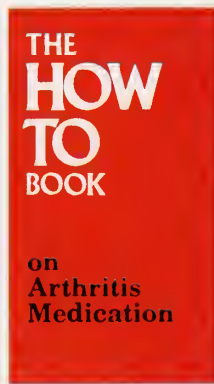
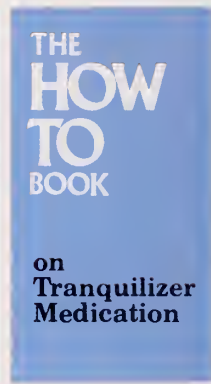
WHAT IF

Roche Laboratories followed up the production and free distribution of 24 million copies of the Medication Education *WHAT IF Book* to patients via physicians, pharmacists and other health care professionals with a new series of booklets on important classes of medicines. The new booklets can be used with your patients to supplement your directions on

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Medicines that matter from people who care

PRINTED IN U.S.A.

An added complication... in the treatment of bacterial bronchitis*



Brief Summary.

Consult the package literature for prescribing information.

Indications and Usage: Cefaclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefaclor.

Contraindication: Cefaclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cefaclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefaclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefaclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistix® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Cefaclor.

Hypersensitivity reactions have been reported in about 1.5

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefaclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefaclor.⁷

Cefaclor®

cefaclor

Pulvules®, 250 and 500 mg

percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefaclor® (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy. Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). (1002818)

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefaclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob Agents Chemother., 8:91, 1975
2. Antimicrob Agents Chemother., 11:470, 1977
3. Antimicrob Agents Chemother., 13:584, 1978
4. Antimicrob Agents Chemother., 12:490, 1977
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), 11:880. Washington, D.C. American Society for Microbiology, 1978
6. Antimicrob Agents Chemother., 13:861, 1978
7. Data on file, Eli Lilly and Company
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr. and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979



Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285
Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630

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Cost is a primary concern of the Doctor in a cost conscious economy. A good malpractice insurance program must provide the services to satisfy budgetary responsibilities of the practice.

Plus provide the protection a Doctor has to have in these times of high frequency and severity of claims.

Through sound investments and strong underwriting guidelines, Medical Assurance Company of Mississippi is doing everything it can to keep premiums down. But, because of the high frequency and severity of claims, holding the line on premiums is becoming more and more difficult.

We want to answer any questions you may have regarding coverage, premiums, and any other areas related to medical malpractice insurance in Mississippi. Give us a call at 1-800-682-6415 or 944-0072 in Jackson.



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DATELINE

Important Dates On MSMA Calendar

Jackson, MS - Two important events are on the MSMA calendar for early 1983. There will be a seminar in Jackson, March 5-6, for MSMA and auxiliary members. The program includes a session on "Critical Issues in Health Care" (March 5) and a political action workshop (March 6). Members and spouses are urged to mark their calendars for that and for another important date, May 11-15, MSMA's 115th Annual Session in Biloxi. More information about both events will be distributed early in 1983.

Exhibitors Invited To Request Space

Jackson, MS - Applications for scientific exhibit space at the 115th Annual Session are now being accepted. Prospective scientific exhibitors are invited to submit requests for exhibit space to MSMA, P.O. Box 5229, Jackson, MS 39216. Exhibitors are asked to state in the letter of application the title of the exhibit, estimated number of linear feet the display will require, and names of all exhibitors. Exhibits by MSMA members are eligible for the Aesculapius Award.

Focus On Malpractice Crisis

Jackson, MS - Public information about the growing medical malpractice crisis in Mississippi will be disseminated soon. Informational brochures and television messages will cite the profession's concern for the situation, describe the cost the public is bearing, and outline proposed solutions. Based on recommendations from the Mississippi Medical Assurance Company, MSMA will sponsor a package of malpractice reform bills for consideration by the 1983 Mississippi Legislature.

Practice Management Tapes Available

Chicago, IL - Overdue accounts can be collected by phone if the physician's staff knows techniques demonstrated in an audiocassette called the Medical Collection Study Course (\$30). Techniques are similar to those used by professional collection agencies, but the course emphasizes the importance of tact and courtesy. That course and another, Handling Patient Calls Effectively (\$25), are both available from the AMA Order Department, P.O. Box 821, Monroe, WI 53566.

Drug Prescribing For Terminally Ill

Chicago, IL - Care of terminally ill patients with severe chronic pain will be the subject of a conference sponsored by the AMA and the Public Health Service, Jan. 28 in Washington, DC. The conference will address concerns about underprescribing. Some legislators have advocated a return to the use of heroin for end-stage patients. The objective of the conference is to foster the use of currently approved drugs to alleviate the suffering of these patients.

Pinworms work the night shift



Artist's interpretation:

The nocturnal egg-laying of the female pinworm causes acute perianal itch...making children shift sleeplessly through the night.

Put pinworms out of work...

Promptly paralyzes pinworms and roundworms

Antiminth® (pyrantel pamoate) has a unique, rapid immobilizing effect on worms. Unlike mebendazole, which blocks glucose uptake—slowly “starving” helminths to death—Antiminth quickly acts on the neuromuscular junction to promptly paralyze parasites.

97% efficacy with a single dose

A single dose of Antiminth delivers rapid clinical and parasitological cures, “Single doses... showed high overall efficacy against *Enterobius vermicularis* (97.2%) and *Ascaris lumbricoides* (97.5%).”¹

Simple, well tolerated therapy

Antiminth offers ease of administration and patient tolerance. “...when compared to the other single dose agents available, [Antiminth] has the advantage of being non-staining and may be better tolerated.”²

The dosage form children like

Antiminth is available as a pleasant tasting, caramel-flavored oral suspension. Effective in just



one dose against pinworm and roundworm—in both children and adults—Antiminth is easy-to-administer and easy-to-take.

Respected around-the-world

In some parts of the world, large populations are afflicted with helminthic infections. Physicians in endemic areas have become experts on parasitic diseases—and have come to rely on Antiminth for the rapid cure of infestations. Antiminth is recommended as an agent of first choice for pinworm and roundworm by leading medical authorities.³

Warnings

Usage in Pregnancy Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions

Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions

The most frequently encountered adverse reactions are related to the gastrointestinal system. Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration

Children and Adults Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

References 1. Pitts NE, Migliardi JR: *Clinical Pediatrics* 13:87, 1974. 2. Modell W: *Drugs of Choice* 1980-1981. C. V. Mosby Co., St. Louis, 1980, p. 362. 3. Goodman LS, Gilman A: *The Pharmacologic Basis of Therapeutics*, 6th edition, MacMillan Publishing Co., Inc., New York, 1980, p. 1032.

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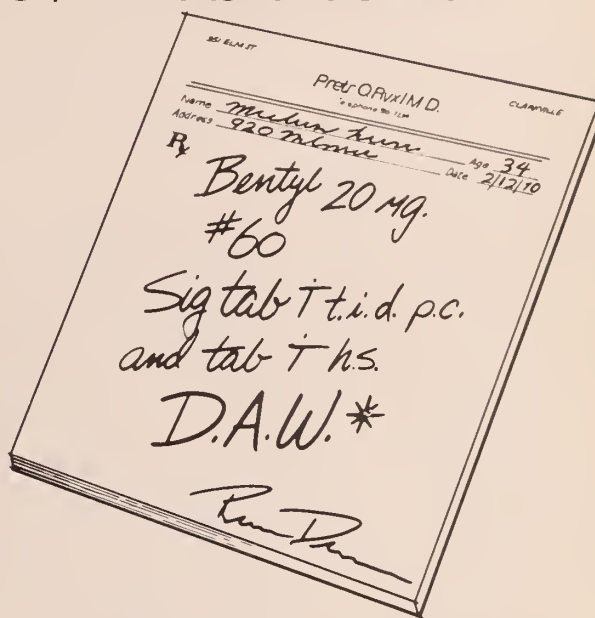
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- ⊕ The bioequivalence of the oral dosage forms permits a choice of tablet, capsules, or syrup that satisfies patient's dosage preferences.
- ⊕ Significant pharmacologic effect in the distal colon compared to placebo,¹ shows how Bentyl controls abnormal motor activity in the irritable colon patient.*

*This drug has been classified "probably" effective for this indication.

Merrell Dow

Reference:

1. Chowdhury AR and Lorber SH: Personal communication, 1980.

(See Product Information on the next page before prescribing Bentyl.)

Although the dose of Bentyl used to show pharmacologic effect was 50 mg, which is a higher single dose than that permitted in the labeling, the dose was considered justified, since the recommended daily dose of injectable Bentyl is 20 mg (2 ml) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg I.M. and, at that time, as a result of the sustained plasma levels from the 20 mg injections at 0 and 4 hours, might show an even higher plasma level than occurs after a single 50 mg dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

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Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations, some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of light-headedness and occasionally local irritation.

DOSEAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (Dilute with equal volume of water.)

Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily.

Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only.

NDT FOR INTRAVENOUS USE

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of July, 1980

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ORIGINAL PAPERS

Radiological Seminar CCXXVI: Right-to-Left Shunting in Perfusion Lung Imaging

DOROTHY S. LIN, M.D.
Jackson, Mississippi

DURING INTRAVENOUS INJECTION of ^{99m}Tc -macroaggregated albumin (NAA) for perfusion lung imaging or radionuclide venography, it may be incidentally discovered that the radioparticles have been shunted from right to left and have lodged in many vital organs such as kidneys, brain and spleen.

Case Example

A 45-year-old male who presented with pain and swelling of both legs during prolonged standing and walking had a radionuclide venography performed for the detection of deep vein thrombosis in his lower extremities. During the procedure, 3mCi of ^{99m}Tc -MAA was injected into a superficial vein on each foot simultaneously. The images of the legs were normal but both kidneys and the spleen were visualized when the inferior vena caval area was imaged (see Figure 1-A). There was also significant uptake in the head and neck areas (see Figure 1-B). The perfusion to both lungs was very patchy with the left lung having relatively more uptake than the right (see Figure 1-C). The chest radiograph obtained on the same day showed diffuse chronic stranding in

both lung fields. The pulmonary outflow tract and right cardiac ventricle were enlarged.

Review of the patient's medical chart revealed that he had a well documented history of ventricular septal defect and had recently developed Eisenmenger's syndrome. Because of the right-to-left intracardiac shunt, some of the ^{99m}Tc -MAA particles were delivered into the systemic circulation, causing blockage of the terminal arteries of the kidneys, spleen and brain. When the study was ordered, the patient's underlying abnormality was overlooked. Fortunately no untoward reaction occurred, and he was released from the hospital after being closely monitored for several hours.

Under normal conditions, there is about 4% of physiological transpulmonary shunting in a lung perfusion study.¹ The amount of shunting would increase if the radioparticles were fragmented during injection through a very fine needle or if there was a delay in imaging after fragmentation had already occurred in the lungs.¹ With a pathological condition, the right-to-left shunting may occur at different levels such as intracardiac (congenital defect),² intrapulmonary (cirrhosis of liver,² pulmonary A-V malformation or fistula,^{3, 4, 5} post "Glenn" operation⁶) or systemic-pulmonary venous (superior vena cava obstruction⁷).

With the assistance of a computer, the degree of shunting can easily be quantified.^{2, 6} The known

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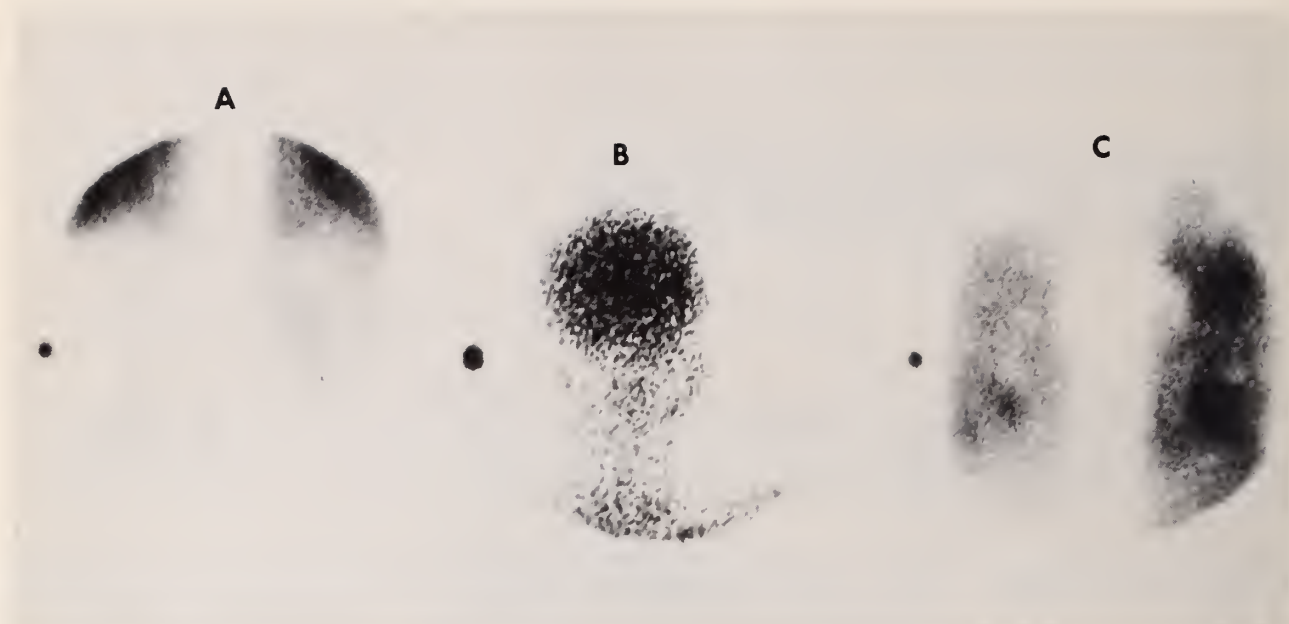


Figure 1. (a) Anterior view of the abdomen with both kidneys and spleen faintly visualized below the perfused lung bases; (b) Anterior view of the head showing uptake in the brain, facial and neck areas; (c) Anterior view of the chest showing inhomogeneous perfusion to both lungs, with the left lung having more activity than the right.

causes of right-to-left shunting are listed according to their prevalence as follows:

Common

1. Right-to-left intracardial shunt²
2. Cirrhosis of liver²
3. Physiological transpulmonary shunt¹
4. Delay before imaging¹

Uncommon

1. Pulmonary arteriovenous fistula^{3, 4, 5} (30% are part of Weber-Osler-Rendu disease)
2. Post superior vena cava-right pulmonary artery (Glenn) anastomosis⁶

Rare

1. Superior vena cava obstruction — systemic-pulmonary venous shunt⁷ ★★★

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References

1. Gates, G. F. and Goris, M. L.: Suitability of radiopharmaceuticals for determining right-to-left shunting: concise communication. *J. Nucl. Med.* 18:255-257, 1977.
2. Anderson, B., Gordon, L., and Buse, M. G.: Intrapulmonary shunting associated with cirrhosis: incidental diagnosis by perfusion lung scan. *Cl. Nucl. Med.* 7:108-110, 1982.
3. Weiss, M. A., Koenigsberg, M., and Freeman, L. M.: Pulmonary arteriovenous malformation: scintigraphic demonstration and analysis. *J. Nucl. Med.* 16:180-182, 1975.
4. Snow, R. M. and Wilson, G. A.: Multiple pulmonary arteriovenous fistulas demonstrated by dynamic radionuclide pulmonary perfusion scanning. *J. Nucl. Med.* 16:328-330, 1975.
5. Lewis, A. B., Gates, G. F., and Stanley, P.: Echocardiography and perfusion scintigraphy in diagnosis of pulmonary arteriovenous fistula. *Chest* 73:675-677, 1978.
6. Pastakia, B., Lieberman, L. M., Levy, J., et al: Quantification of intrapulmonary shunting in superior vena cava-right pulmonary artery (Glenn) anastomosis. (Abstr.) *J. Nucl. Med.* 20:670, 1979.
7. Hutchins, W. W., Kirchner, P. T., and MacMahon, H.: Perfusion lung scan in superior vena cava obstruction: demonstration of venous collaterals and systemic-pulmonary venous shunt. *Am. J. Roentgenol.* 138:754-756, 1982.

Health Care Reimbursement in Mississippi: Problems and Possible Solutions

THOMAS J. BROOKS, III
Jackson, Mississippi

MISSISSIPPI HAS AN UNPARALLELED opportunity to address and to successfully deal with the twin problems of inpatient health care cost increases and diminished accessibility of public patients (Medicare, Medicaid, and self-pay) to area hospitals. The reasons diminished accessibility is likely to occur are discussed in this paper. Both problems relate directly to the manner in which hospitals are reimbursed, and are solvable. It is suggested that one issue cannot satisfactorily be addressed without addressing the other. The largest portion of national health care expenditures, 41.2% in 1981,¹ is spent for hospital care. Therefore, improvements to inpatient reimbursement systems must be set in place if cost increases are to be materially abated. *If there were little or no differential in payments to hospitals for Medicare and Medicaid patients versus private insurance and Blue Cross patients, and if a sharing mechanism, or pool, from which to help pay for care of indigents existed, the financial ability of Mississippi hospitals to care for public patients would be immeasurably enhanced.* In reality, often wide differentials in reimbursement exist and changes are being set in place which will cause these differentials to enlarge.

Hospital Costs

When the threat of the Carter Administration's hospital cost containment proposal ceased to exist in 1980, national health care costs climbed. These costs increased by 15.1% in 1981, the second largest increase in 15 years. A key factor in that increase was the 17.5% increase in hospital costs.²

The following six issues, it is suggested, warrant the attention of the public and bear directly on successful resolution of the twin problems.

Executive Director, Mississippi Health Care Commission. (The views herein expressed are those of the author and not necessarily those of the Mississippi Health Care Commission.)

1. *Mississippi will enter a period of runaway health care costs, which will exceed previous periods of cost increases, unless substantive action is taken.* Personal interviews conducted by the author reveal that for companies doing business in Mississippi, health insurance premium increases in the 30-35 percent range are not uncommon. Some increases far exceed this range. As the federal programs, Medicare for the elderly and Medicaid for the poor, are further curtailed in funding or scope of coverage to meet national budget goals, more "unmet costs" will be shifted to private insurers, and thus, to businesses — the "cost shifting" phenomenon. If unchecked, this shift could conceivably cause premiums paid by Mississippi businesses to double or triple within the next several years. It is doubtful that the business community will easily accommodate an increase of this magnitude. Elevated premiums mean increased cost of goods produced and/or diminished margins of profit.

2. *Incentives created by the "third party" reimbursement system, as presently structured, should be examined.* With insurance premiums having been paid and with many policies offering "first dollar" coverage, there is little incentive for patient and provider to economize at the time at which care is delivered and the system may serve to insulate patient and provider from consideration of the cost of care. While this system has protected the insured against large episodic hospital expenses, it has also unquestionably been a major contributor to increased health care costs. Greater cost sharing by employees may encourage some economy, but only until a policy's deductible amount has been met, if such is required. In such cases as the employee has taken out a supplemental policy to cover deductibles, the price sensitivity required for true "market-place" competition is largely absent.

3. *The practice of reimbursing hospitals on such bases as the patient's length of stay and the number*

of procedures performed on the patient should be examined. Logically, such incentives may promote excessive stays and use of tests and procedures of marginal necessity, utilization review notwithstanding.

4. *Unless changes are made, Mississippi is headed for a two-tiered system of care, one for privately insured patients, one for public patients.* Equalization of payments from all payors, public and private, to compensate for hospital patient mix (private vs. public) has been implemented in some states with the express purpose of financially strengthening hospitals which serve large numbers of public patients. As a society, we are increasing incentives for hospitals to care for private patients and limiting incentives for hospitals to care for public patients. The impact of these policies is being seen as hospitals compete more and more for the privately insured patient rather than for the most competitively priced product. We look in consternation when hospitals refuse to take public patients, yet they are doing precisely what economic incentives instruct them to do. Should not these incentives be questioned?

In essential terms, private insurance reimburses on the basis of "billed charges," Medicare and Medicaid on the basis of "allowable costs." The latter two programs typically pay hospitals less for their patients than commercial insurance policies pay for their subscribers. Hospitals which serve large volumes of public patients, including indigents, the poor and near poor, seasonal workers, the unemployed, and persons with inadequate or no health insurance, cannot, therefore, be expected to compete equally with hospitals which serve primarily privately insured patients. This is precisely why, without changes in the reimbursement system, increased "competition" as espoused by some on-lookers will have a clearly negative, rather than positive, effect on Mississippi's voluntary hospital system.

To say that what is needed is simply more money from Medicare (approximately 35 percent of the typical hospital's business) and Medicaid (8-10 percent) is to avoid coming to grips with the problem. The hope for more money from federal programs, at least in the next couple of years, is unrealistic and runs counter to evidence indicating that federal entitlement programs will continue to be reduced in funding and/or scope of coverage.

5. *It is necessary for hospitals which attempt to care for all patients to maintain a reasonable mix of private versus public patients.* In 1982, "open" competition with no state oversight of capital outlays

through the Health Planning and Certificate of Need program will not bode well for Mississippi, especially its county, city, state, and teaching hospitals, unless some adjustments can be made which will enable institutions to compete on a more equal basis. Other states have attempted to promote fairer competition between institutions by allowing for patient mix when reimbursement is made from all payors to hospitals.

With the increasing prominence of private investor-owned and private nonprofit hospitals, the patient mix of many traditional community hospitals in Mississippi may be altered. In some cases, public patients may find access to area hospitals difficult and, conceivably, the taxpayer may be faced with picking up the long term indebtedness of a county hospital which cannot remain open because private patients are now going elsewhere. Such a facility becomes a prime candidate for lease or sale, if and when such sales are ever allowed under state statute, either of which may alter patient mix.

Before a new hospital is established, the extent to which all patients are going to be cared for should be considered. This practice will help make known whether additional demands may be placed on hospitals that care for public patients, on the state's charity hospitals, and on the University of Mississippi Medical Center.

Twenty-two of 74 Mississippi Hill-Burton hospitals have already completed their Uncompensated Care obligation and 70% will have completed such obligation by 1992. The total annual Uncompensated Care obligation of the remaining 52 hospitals is \$5,146,016, an average annual obligation of \$98,962 per hospital. There are Mississippi hospitals which individually provide in excess of \$5,000,000 per annum in bad debt, charity and other contractual allowances. Hypothetically, if "bottom line" pressures forced Hill-Burton hospitals to render free care only to the extent of each facility's remaining obligation, the effect on public patients in Mississippi would be devastating.

6. *Reimbursement of hospitals on a retrospective basis should be reconsidered, with thought given to a system with incentives for economy, rather than usage.* The Mississippi Medicaid program now reimburses hospitals on a prospective basis. Congress is being asked by the Department of Health and Human Services to place the Medicare program on a prospective reimbursement basis nationally. The American Hospital Association proposed in the spring of 1982 its version of a limited prospective reimbursement plan for Medicare patients, estimating a savings of \$1 billion in Fiscal Year 1983.

Under a prospective reimbursement system, maximum charges and revenues are set in advance. If the hospital serves its patients for less than the pre-set amount of payment, it can keep the difference; if the amount is exceeded, the facility must absorb the difference. In theory, the incentive is to use hospitalization efficiently and economically.

A serious problem may ensue in Mississippi if and when both federal programs have made the transition to the prospective mode of payment and private insurers are paying on the basis of charges, computed retrospectively. "Cost shifting" will almost surely accelerate. It has been estimated by the National Insurance Association of America (NIAA), in personal communication with the author, that in Mississippi approximately \$25,000,000 in costs was shifted from the governmental sector to the private sector in 1980, up from approximately \$19,000,000 in 1979. These amounts include what would not have been shifted from the governmental sector if all payors had paid on an equal basis.

The U. S. Department of Health and Human Services is now making limited use of the prospective reimbursement system and has imposed new limits on a cost per discharge rather than cost per diem basis (discussed later). Reimbursement by unit of diagnosis is synonymous with the Diagnosis Related Group (DRG) payment concept. Under this approach, hospitals are reimbursed a prenegotiated amount for each admission diagnosis, regardless of the patient's length of stay or the number of procedures performed. The incentives created are readily seen.

Does Prospective Reimbursement Save Money?

The United States General Accounting Office has compared states using retrospective reimbursement systems with states using various types of prospective systems. GAO reports:

"For the years 1975-77, the average expenditures per case for all community hospitals increased 14.9 percent annually; for States having retrospective systems, the annual rate of increase was 17.9 percent, and for States using a prospective system, the expenditures increased on the average 13.9 percent per year.

"We concluded that while the hospital expenses per case continued to grow in all States in recent years, the rate of increase had generally been lower in States with prospective ratesetting programs. This lower growth rate suggested that the ratesetting programs had successfully diminished the cost escalation spiral. In some States, the

rates of increase in hospital costs had dropped dramatically. This was especially true for States with mandatory-regulatory-type prospective ratesetting programs. Thus, it appeared that the mandatory-regulatory-type program offered the greatest potential for controlling hospital costs."³

Other affirmative studies exist, yet, were not cited here in the interest of conserving space.

The Cost Shift

There are notable examples of voluntary efforts to control increasing health care costs in the states. However, when all voluntary measures are aggregated, whatever savings will accrue may be offset by costs shifted to the private patient if further Medicare and Medicaid reductions are made.⁴ The cost shift occurs because private insurance policies, as in service contracts, pay charges as long as they are "reasonable." Blue Cross pays the lesser of charges or costs plus 13 percent (the lower of costs or charges, costs equaling total Blue Cross patient days times the adjusted cost per day and charges equaling total Blue Cross covered charges) and Medicare and Medicaid have traditionally reimbursed on the basis of allowable costs (lesser of charges or allowable costs). Under an indemnity policy, the insurance carrier pays a set amount per service directly to the patient, who is then responsible for his or her bill, with no negotiation between the insurer and insured, nor between the insured and the provider of services.⁵

A number of hospital expenses are not allowed under, for example, the Medicare program. Initially, payment was excluded for accumulation of equity capital (non-profit institutions), bad debts and charity care. In 1972, limits were placed on payments to individual hospitals, based on the reasonableness of their costs. In 1980, a new basis for allocation of malpractice insurance premiums was established, reducing national Medicare payments in that year alone by in excess of \$300 million.⁶

The Health Care Financing Administration (HCFA) has placed limits on other reimbursable hospital inpatient costs, effective October 1, 1982. The new limits will cover total inpatient operating costs, including the costs of general routine service, special care, and ancillary services. The new limits will apply on a cost per discharge basis rather than a cost per diem basis and will be adjusted to reflect differences in the mix of Medicare cases treated by each hospital. There are some exceptions in the new guidelines.⁷

The emerging budget philosophy in Washington

is apparent. This philosophy is that federal outlays for entitlement programs must be reduced. It is undoubtedly understood that federal reductions in scope of coverage or funding may result in more shifting of "unmet" costs to private patients and their employers. Washington apparently sees its task as reducing federal outlays; if a concomitant cost shift to private patients occurs, states are seen as being able to do something about this on their own.

Medicare/Medicaid Waivers and Demonstration Projects

The Health Care Financing Administration has participated in a variety of prospective reimbursement and state rate setting demonstration projects. Some states have been granted latitude in setting hospital reimbursement rates to cover important hospital operating expenses not theretofore allowed. Waivers for statewide systems governing all payors have been granted to Maryland, New Jersey, Massachusetts, and New York.⁸ Prospective reimbursement governing all payors is, presumably, thought to be important in researching overall economies in operation which will offset payments resulting from liberalized reimbursement criteria for Medicare patients.

HCFA feels that sufficient information has been or will be gathered from existing waived states on the potential of prospective reimbursement and is now seeking demonstration projects testing diagnosis related unit of payment systems and other statewide rate setting programs.⁹

Programs in Other States

The four states previously mentioned, Maryland, New York, New Jersey, and Massachusetts, are experimenting with a variety of reimbursement measures, including one or more of the following, which represent the core of new reimbursement concepts.

1. State prospective hospital payment systems governing all payors.
2. Reimbursement by Diagnosis Related Groups (DRGs) or other case mix reimbursement types of payment plans not based on length of hospitalization or extent of services provided.
3. Use of a uniform definition of hospital reimbursable costs, thereby eliminating payment differentials, avoiding the cost shift, and making indigent care a reimbursable cost of doing business.
4. Limitation on hospital charges to private patients.
5. Establishment of a "pool" or other equity mechanism from which to cover hospital bad

debts and charity care.

6. The bolstering of financially stressed hospitals by equalization of payment.
7. The requirement that uniform cost, billing and utilization data be submitted by hospitals.
8. The use of a built-in hospital revenue cap limiting the maximum amount that will be paid.
9. The requirement for Quality Assurance or Utilization Review.

Clearly, some other states have been seeking solutions to the same problems now confronting Mississippi. If implemented in Mississippi, these measures would seem to obviate the need for additional charity hospitals.

In Closing

The overall concept of new payment systems as herein outlined is neither revolutionary nor radical as can be seen by the fact that several states are now employing these principles of their own volition.

The foregoing is not to imply that problems with prospective and DRG payment systems do not exist, only that such systems should perhaps be investigated as having potential benefit for Mississippi. These approaches protect the private system in that patients may still select the hospital and physician of their choice, not an ingredient in some preferred provider plans.

★★★

2688 Insurance Center Drive (39216)

References

1. Gibson, Robert M. and Waldo, Daniel R.: National Health Expenditures, 1981. Health Care Financing Review, Sept. 1982, p. 1.
2. National Medical Costs Increase to \$287 Billion. L. A. Times/Washington Post Service (article appeared in Clarion-Ledger, Jackson, MS, Aug. 2, 1982).
3. Ahart, Gregory J. (Dir., U. S. General Accounting Office): Letter to U. S. Senator Bob Packwood. Subject: Information on Prospective Reimbursement Systems (GAO/HRD-82-73). May 10, 1982.
4. Orsini, Louis A.: Medicare/Medicaid — The Agony and The Ecstasy. May Trends, (a publication of George S. May International Company). Vol. 15, No. 1.
5. For brief instructive discussion regarding third-party reimbursement systems, see Cost-Based Reimbursement: Health Care's Disease by Barbara W. Greenman. Published by Institute of Health Planning, Madison, WI. January 1982. p. 19.
6. For a concise discussion of federal reimbursement under the Medicare and Medicaid programs and the cost-shifting phenomenon, see Orsini, Louis A.: Medicare/Medicaid — The Agony and The Ecstasy. May Trends. Vol. 15, No. 1.
7. Federal Register, Vol. 47, No. 190, pp. 43282 & 43296, Sept. 30, 1982.
8. Federal Register, Vol. 47, No. 196, p. 44613, October 8, 1982.
9. Ibid. p. 44614.



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Tablets

DESCRIPTION

Each prolonged action tablet contains:

Phenylephrine Hydrochloride	25 mg
Phenylpropanolamine Hydrochloride	50 mg
Chlorpheniramine Maleate	8 mg
Hyoscyamine Sulfate	0.19 mg
Atropine Sulfate	0.04 mg
Scopolamine Hydrobromide	0.01 mg

Ru-Tuss Tablets act continuously for 10 to 12 hours.

Ru-Tuss Tablets are an oral antihistaminic, nasal decongestant and anti-secretory preparation.

INDICATIONS AND USAGE Ru-Tuss Tablets provide relief of the symptoms resulting from irritation of sinus, nasal and upper respiratory tract tissues. Phenylephrine and phenylpropanolamine combine to exert a vasoconstrictive and decongestive action while chlorpheniramine maleate decreases the symptoms of watering eyes, post nasal drip and sneezing which may be associated with an allergic-like response. The belladonna alkaloids, hyoscyamine, atropine and scopolamine further augment the anti-secretory activity of Ru-Tuss Tablets.

CONTRAINDICATIONS Hypersensitivity to antihistamines or sympathomimetics. Ru-Tuss Tablets are contraindicated in children under 12 years of age and in patients with glaucoma, bronchial asthma and women who are pregnant. Concomitant use of MAO inhibitors is contraindicated.

WARNINGS Ru-Tuss Tablets may cause drowsiness. Patients should be warned of the possible additive effects caused by taking antihistamines with alcohol, hypnotics, sedatives or tranquilizers.

PRECAUTIONS Ru-Tuss Tablets contain belladonna alkaloids, and must be administered with care to those patients with glaucoma, or urinary bladder neck obstruction. Caution should be exercised when Ru-Tuss Tablets are given to patients with hypertension, cardiac or peripheral vascular disease or hyperthyroidism. Patients should avoid driving a motor vehicle or operating dangerous machinery (See Warnings).

OVERDOSAGE Since the action of sustained release products may continue for as long as 12 hours, treatment of overdoses directed at reversing the effects of the drug and supporting the patient should be maintained for at least that length of time. Saline cathartics are useful for hastening evacuation of unreleased medication. In children and infants, antihistamine overdosage may produce convulsions and death.

ADVERSE REACTIONS Hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia may occur. Other adverse reactions to Ru-Tuss Tablets may be drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, dizziness and insomnia. Large overdoses may cause tachypnea, delirium, fever, stupor, coma and respiratory failure.

DOSAGE AND ADMINISTRATION Adults and children over 12 years of age, one tablet morning and evening. Not recommended for children under 12 years of age. Tablets are to be swallowed whole.

HOW SUPPLIED:

Bottles of 100 Tablets

Bottles of 500 Tablets

Federal law prohibits dispensing without prescription.

NDC 0524-0058-01

NDC 0524-0058-05

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MANUFACTURED BY:

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Springfield Gardens, New York 11413

RU-TUSS[®]

Expectorant

DESCRIPTION

Each fluid ounce of Ru-Tuss Expectorant contains:

Codeine Phosphate	65.8 mg
(WARNING: MAY BE HABIT FORMING)	
Phenylephrine Hydrochloride	30 mg
Phenylpropanolamine Hydrochloride	20 mg
Pheniramine Maleate	20 mg
Pyrimamine Maleate	20 mg
Ammonium Chloride	200 mg
Alcohol	5%

Ru-Tuss Expectorant is an oral antitussive, antihistaminic, nasal decongestant and expectorant preparation.

INDICATIONS AND USAGE Ru-Tuss Expectorant is indicated for symptomatic relief of upper respiratory congestion associated with pharyngitis, tracheitis, bronchitis, and allergic rhinitis. Also, for the temporary relief of symptoms associated with hay fever, allergies, nasal congestion and cough due to the common cold.

CONTRAINDICATIONS Hypersensitivity to antihistamines. Concomitant use of an anti-hypertensive or antidepressant drug containing a monoamine oxidase inhibitor is contraindicated.

Ru-Tuss Expectorant is contraindicated in patients with glaucoma, bronchial asthma and in women who are pregnant.

WARNINGS Ru-Tuss Expectorant contains codeine phosphate, therefore, the patient should be warned of the potential that this drug may be habit forming. Ru-Tuss Expectorant may cause drowsiness. Patients should be warned of the possible additive effect caused by taking antihistamines with alcohol, hypnotics, sedatives and tranquilizers.

PRECAUTIONS Patients taking Ru-Tuss Expectorant should avoid driving a motor vehicle or operating dangerous machinery (See Warnings). Caution should be taken with patients having hypertension, diabetes, hyperthyroidism and cardiovascular disease.

Caution should also be used in patients with pulmonary, hepatic or renal insufficiency.

ADVERSE REACTIONS Ru-Tuss Expectorant may cause drowsiness, lassitude, giddiness, dryness of mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, and insomnia. Overdoses may cause restlessness, excitation, delirium, tremors, euphoria, metabolic acidosis, stupor, tachycardia and even convulsions.

DOSAGE AND ADMINISTRATION Adults: 1 or 2 teaspoonfuls, orally, every 4 hours, not to exceed 10 teaspoonfuls in any 24-hour period.

Children 6 to 12 years of age: $\frac{1}{2}$ the adult dose, not to exceed 6 teaspoonfuls in any 24-hour period. Children 2 to 6 years of age: $\frac{1}{4}$ teaspoonful every 4 hours, not to exceed 3 teaspoonfuls in any 24-hour period. Children under 2 years of age: Use as directed by a physician.

HOW SUPPLIED: (16 fl. oz.)

Pint Bottles

Federal law prohibits dispensing without prescription.

NDC 0524-1010-16



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The Disability Process

JOHN S. BARR, M.D.

Jackson, Mississippi

THE GOAL OF THIS DISCOURSE is to foster an increased understanding between the medical community of Mississippi and the Disability Determination Services (DDS). That a dialogue is necessary between the physician who cares for or examines the applicant and the agency that makes the disability determination is self evident. Disability and the determination thereof has been defined and regulated by the Congress. Every state agency (DDS) is subject to a large body of regulations which mandate and control the disability determination process. No change in this process may be effected on the state level. Only the Congress has the power to change the definition of disability or the process by which disability is determined.

Thus any citizen who disagrees with the process must address his complaints to his or her representatives in the Congress. State agency personnel are powerless to effect changes. This will be emphasized in our discussion of the decision making process.

I should like to emphasize at this juncture that, right or wrong, the Congress has made disability a legal concept, not a medical one. It has defined disability as "the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." This definition, *per se*, excludes all temporary impairments irrespective to their severity. The original definition required that the impairment(s) be "of long continued and indefinite duration" (1956). The "12 months duration" was inserted in 1965.

History

In 1935 the Social Security Act was passed into law by the 74th Congress. This act is now entitled as RSI (Retirement Security Income) and is the original

"old age pension." In those halcyon days, it was believed that the 1% tax on employees and employers would support the system.

In 1939 benefits for dependents and survivors were authorized. Other amendments, which had to do with variations in the tax structure, were added in the intervening years.

In 1947-48, Social Security Administration (SSA) was beginning to opt for disability insurance.¹ By 1950, it was clear that the issue was going to be highly controversial. The first proposals were rigorous and restrictive, requiring a "recent substantial attachment" to the labor force.² The conservatives maintained that the physical incapacity for work is difficult to determine objectively. It was felt that there was much room for abuse. We all know from the experiences in our own practices how true this is.

Despite much in-fighting and debate, the first step was accomplished in 1954 when the "disability freeze" was passed into law. Thus, the disabled worker was prevented from losing his insured status because of loss of required time of coverage.³ (A certain amount of time in covered employment was, and still is, required to qualify for benefits.) The American Medical Association saw this as the first step toward socialized medicine and reacted vigorously. The AMA was subsequently placated by the idea of having state agencies make the decisions, thus protecting physicians from direct involvement with the federal government. The SSA along with organized labor were aligned against the AMA, the insurance industry, and the Chamber of Commerce. What SSA needed was presidential backing and this it got from Eisenhower. The plan was that all these workers whose premiums were waived would be funneled into Vocational Rehabilitation where they would be given proper counseling and treatment and subsequently returned to the labor market.⁴ As we all know, this dream turned out to be just that. In 1954, the "freeze" was voted into law.

The next step was obvious: to proceed from the "freeze" to cash benefits for disabled workers. In 1956, L. B. Johnson was the new and strong Democratic party leader. Senator W. F. George of Geor-

Dr. Barr is chief medical consultant, Mississippi State Disability Determination Unit, Jackson, Mississippi.

DISABILITY/Barr

gia sponsored disability insurance in the Senate and Johnson set up the winning coalition. The coalition succeeded with a vote of 47 to 45. The SSA had its disability insurance (D.I.) and the Democrats had a campaign issue. The AMA had fought against it and organized labor had fought for it.

After enactment, increments came relatively easily. Dependents were added in 1958; in 1965 the duration of 12 months was put into the definition of disability (in lieu of "continued and indefinite duration"); in 1972 the waiting period was reduced to five months. A high degree of administrative discretion was inherent in determining disability.⁵ Lack of faith in SSA was the major reason for the conservative's insistence upon state agencies as decision makers. Robert Ball, who served as Commissioner of SS from 1962 until 1973, is responsible for much of the liberalism in decision making that occurred in the sixties and early seventies.

What is the extent of current coverage? Robert Ball wrote a book in which he outlined some pertinent facts about the disability program.⁶ In it he pointed out that as of January 1, 1977, there were 87 million workers under 65 (55 million men and 32 million women) who were insured against the loss of their earnings in the event of a long term disability. (Many of the dependents of these people are also covered.)⁷ As of June 1977, 2.8 million workers were receiving disability benefits. (As were 391,000 persons who had been disabled since childhood, 122,000 disabled widows and widowers, nearly one-half million wives and 1.5 million children of disabled workers.)⁸

The SS disability program is the largest of its kind in the world. Administrative problems have been serious (and continue to be serious). This has been compounded by the addition, in 1974, of the Supplemental Security Income (SSI) program. This was created in 1972 to set federal standards of income support for the needy aged, blind, and disabled.

The Mississippi DDS

The DDS in Jackson is responsible for the determining of disability in applicants eligible under DI and SSI. The regulations for determining disability are basically the same, though there are some minor variations. Space does not permit discussion of these differences. The DDS is made up of disability examiners and supervisors, administrative personnel, and medical consultants. Each group has its function. The goal is for each group to make its contribu-

tion towards the making of an accurate decision (using a specific set of guidelines and regulations) and to make that decision in as short a period of time as is commensurate with accuracy.

In order to clearly demonstrate the decision making process, we shall trace a case through the DDS. Because of limited space, we must omit technical details and resort to a brief overview.

Case Description

The applicant applies at the district office (DO). A form with the claimant's allegations is sent to the DDS. The case is assigned to a disability examiner who then begins the process of gathering information upon which to base an adjudication. The examiner contacts the claimant to be certain that the treatment sources named at the DO are the correct ones. He or she then contacts the treatment sources to obtain all the information available from these sources. Not only does the examiner try to obtain all medical evidence available, but he or she obtains educational and vocational background as well as other technical information.

At this juncture the examiner may find that there is enough information upon which to base a decision. He may, at this time, seek the advice of an agency physician as to severity of impairment, adequacy of medical documentation, or prognosis as to impairment duration. If medical documentation is found to be inadequate, the examiner-physician duo may opt to call a treating source for further clarification or they may opt to obtain a consultative evaluation.

Let me emphasize at this point that the information sought must be, as nearly as possible, objective evidence. It should be probative, the kind a physician might give under oath in a court of law. Opinion, not supported by objective clinical, laboratory, and x-ray findings, is not acceptable. Symptoms without objective corroboration do not constitute a medically determinable impairment. A clearly diagnosable disease or injury process must be present before an impairment may be said to exist. Pain, *per se*, without a clear cut diagnosed causation, is not considered an impairment. Generalized muscle weakness, without a diagnosed cause, cannot, under the law, be declared to be an impairment. And, remember, the Congress has made disability a legal concept, not a medical one. It is the express intent of the Congress that all impairments be determined in the manner stated above.

There are basically four ways a case may be allowed and a wide variety of ways it may be denied. Space does not permit a detailed analysis of all these. It suffices to say that an allowance may be made as a

meeting of a list of specific medical criteria (called the "listings"), or the allowance may be made based upon an impairment equally severe or worse than that given in the listings, or it may be made upon the basis of a combination of medical and vocational factors. The latter deals with cases where the impairment or combination of impairments may result in a decrease in residual functional capacity (RFC, as determined by an agency physician) that results in a medical-vocational allowance (e.g., a 61-year-old pulpwood hauler with three grades of education who suffers a below the knee traumatic amputation of one lower extremity). After the case has been documented, the examiner makes a decision; it is signed by an agency physician if he agrees that the documentation is adequate and if he agrees with the decision.

It is important that the entire medical community understand that the state DDS does not make disability decisions upon its own recognizance, but that it follows a relatively rigid set of guidelines, and that its decisions are subject to review at several levels. Allowances, made out of sympathy and kindheartedness, will more than likely be reversed at the review level. The same holds true for denials made based upon feelings of deprecation and vindictiveness.

The denied applicant has the right to appeal the decision. The appeals process is too complex to be given here in detail. Briefly, there is an informal remand, a reconsideration process, and, further along, an appeal to an Administrative Law Judge (ALJ). The ALJ is not bound by the degree of objectivity required of the DDS.

Conclusion

The budget estimate for fiscal year 1982⁹ has set aside \$167,300,000,000 for general retirement and disability insurance. Current members of the SS system, whether working or retired, have been promised future benefits exceeding four trillion dollars.¹⁰ These numbers overwhelm my imagination.

It is my sincere hope that the Mississippi DDS may establish a dialogue, an avenue of understanding, with the medical community of Mississippi, so that we may work in concert toward more accurate (under the law) decisions.

No change in the system may be effected at the state agency level. Only the Congress may effect change.

★★★

P.O. Box 1271 (39205)

Bibliography

1. Derthich, Martha, *Policy-making for Social Security* (1979), Brookings Institution, Washington, D.C., page 297 f.f.
2. Ibid, page 298
3. Ibid, page 300
4. Ibid, page 303
5. Ibid, page 309
6. Ball, Robert M., *Social Security Today and Tomorrow* (1978), Columbia University Press, N.Y.
7. Ibid, page 151
8. Ibid, page 152
9. Britannica Book of the Year (1982), Encyclopedia Britannica, Inc., Chicago.
10. Munnell, Alicia H., *The Future of Social Security* (1977), The Brookings Institution, Washington, D.C., page 1.

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PROFILES

Ellis M. Moffitt, M.D. Trustee, District 5

Jackson area businessmen, insurance agents and physicians have formed a coalition to help stabilize health care costs in Mississippi. A guiding force behind the coalition is Dr. Ellis M. Moffitt, chairman of the MSMA Board of Trustees.

The Jackson allergist is noted for his concern for rising health care costs and for his energetic support of efforts to slow the increase. He is vice-chairman of the Board of Directors, Blue Cross & Blue Shield of Mississippi, Inc., and is a member of the Board of Directors of the Jackson Chamber of Commerce. He has served as chairman of the Board of Directors of the Mississippi Foundation for Medical Care, as a member of a special task force of the Governor's Office of Comprehensive Health Planning, and as a member of the executive staff, University of Mississippi Medical Center.

In addition to serving on the MSMA Board of Trustees, Dr. Moffitt has held many other positions of leadership in the association. He is past president of Central Medical Society, the Mississippi Society

of Internal Medicine, and of the Southeastern Region of the American Association for Clinical Immunology and Allergy. He is charter president of the Jackson Academy of Medicine — Internal Medicine Society and former chief of the medical staff, Mississippi Baptist Medical Center. He is currently a clinical professor of medicine at the University of Mississippi School of Medicine.

This influential and respected physician did not begin his professional life as a physician. He entered the field of business after receiving his B.A. degree from Mississippi College. His interest in medicine was stimulated during the eight years he worked for a pharmaceutical company, he says, but it was primarily the encouragement of the late Dr. Edley Jones of Vicksburg which led him to enroll in medical school.

He received his M.D. degree from Tulane University School of Medicine. He interned at the Mississippi Baptist Medical Center in Jackson, and it was during this time that he had the opportunity to work with the late Dr. George W. Owen, who noticed his interest in patients with allergic diseases and encouraged him to pursue that specialty. After completing fellowships at the University of Virginia and the University of Michigan, Dr. Moffitt began practice in Jackson in 1964.

The busy and productive professional life which he leads permits some free time to enjoy one of his favorite hobbies — the making of fine furniture. The interest began, he says, when he completed a project from a kit, making do with whatever equipment he had. The hobby has grown, and he now has his own woodworking shop at his home and specializes in making reproduces of antiques.

Dr. Moffitt is married to Dr. Nina Goss Moffitt, a psychiatrist. The family includes two children: John, now completing a residency in pediatrics at the University Medical Center in Jackson; and Ginny, who is completing medical school this year and looking toward a specialty in obstetrics and gynecology.



Dr. Ellis Moffitt was photographed as he addressed a medical group recently, one of many speeches he has delivered as chairman of the MSMA Board of Trustees.

Third in a series featuring members of the MSMA Board of Trustees



Dr. J. O. Manning, photographed in NASTAR competition.

J. O. Manning, M.D. Trustee, District 5

Dr. J. O. Manning credits the influence of a Millsaps college professor with his decision to enroll in medical school. Although he had always had an interest in becoming a doctor, Manning decided, while a student at Ole Miss, to pursue a degree in business. After receiving the B.B.A. in 1951 and serving for two years in the U. S. Air Force, he returned to Jackson and entered the real estate business. He continued to have an interest in medicine, however, and sought out the advice of Dr. Joseph B. Price, his Sunday School teacher and chairman of the chemistry department of Millsaps College.

With the encouragement of Dr. Price, he took the courses necessary for admission to medical school and received his degree in 1959 from Tulane School of Medicine. He interned at Charity Hospital in New Orleans, and completed residencies in orthopedic surgery at Tulane and at Confederate Memorial Medical Center in Shreveport.

Dr. Manning is board certified in orthopedic surgery, and is a member of Central Medical Society, Mississippi State Orthopaedic Society, the American Medical Association, the American Academy of Orthopaedic Surgeons and the Clinical Orthopaedic Society. He was elected to the MSMA Board of Trustees in 1978, representing District 5.

He spends most of his time in his practice, he says, and speaks about unique rewards of the specialty of orthopedics. Through his involvement with athletic teams of various educational institutions, he

has had the opportunity to develop friendships with many high school and college athletes, many of whom have gone on to careers in professional sports. He says he has met many people and established many friendships which he might not have had otherwise.

His interest in sports is not limited to being a spectator. He is an active participant in a number of sports. He enjoys duck hunting, running, and is an avid tennis player. (He has been chairman of the annual MSMA tennis tournament as well as the annual Red/Blue Tennis Tournament conducted in Jackson by the Ole Miss Alumni Association.) One of his favorite interests is skiing, which he took up late in life, he says, and which has resulted in the athletic accomplishment that has given him the greatest pleasure — a silver medal he won in downhill slalom in NASTAR competition.

Dr. Manning's interest in politics was further stimulated when he became chairman of MSMA's political action committee. He is particularly pleased with the increase in both financial support of MMPAC and active participation in the political process by MSMA members.

Dr. Manning is immediate past president of River Hills Tennis Club. He is also a deacon at First Presbyterian Church in Jackson. He and his wife, Sudie, an accomplished artist, are the parents of four children, and just recently became grandparents for the first time.



The President Speaking

Be a PAC-MAN

SIDNEY O. GRAVES, JR., M.D.
Natchez, Mississippi

I want to talk about the PAC. Some of you may immediately visualize the video game, where the clickity little blip scoots across the screen devouring all the little bleeps in sight. That is not what I had in mind. The PAC-MAN I mean belongs to the MMPAC/AMPAC (the Mississippi Medical Political Action Committee and the American Medical Political Action Committee, respectively).

MMPAC is a voluntary non-profit unincorporated group whose membership consists chiefly of physicians. It is led by a nine member board which is appointed by the Board of Trustees of the Mississippi State Medical Association. MMPAC participates in campaigns of candidates for the Mississippi Legislature in an effort to assure the election of individuals who are responsive to the concerns of the profession.

AMPAC is the political action committee of the American Medical Association. AMPAC provides political educational services and works to support candidates for the United States Congress.

AMPAC has recently reported that 84.7% of the candidates it assisted in this last campaign were elected. This is the highest success rate in the twenty-one year history of AMPAC. A total of \$18,500.00 was contributed to six Mississippi candidates, all of whom won their races. In no race were both candidates funded by AMPAC. This is a very impressive rate, but we can't rest on our laurels. We now have to begin thinking very seriously about the state campaigns to be held this next summer and fall.

For the billing year 1980-82, a total of \$43,694.00 was contributed to MMPAC. For 1982-83, the contributions are about the same as last year — but this is not enough. We need a War Chest large enough to defeat some of our unrelenting enemies and support our friends. This is the year to flex our muscles.

For those of you who have joined the PAC, thank you. For those of you who have not, please do so. Forego one night out "on the town" and you will have the money for the PAC contribution.

The manner in which you will practice medicine in the future is being determined by legislative action now. Become a Sustaining Member of both MMPAC and AMPAC for only \$100.00. That's very little to pay to become a real PAC-MAN.

EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XXIII, Number 12

DECEMBER, 1982

Pharmacists May Propose Prescriptive Authority Legislation

The Mississippi Pharmaceutical Association is currently considering the concept of "Prescriptive Authority" and the possibility of including this program as a part of the new Pharmacy Practice Act to be introduced in the upcoming session of the State Legislature. The concept of the "Prescriptive Authority," patterned after the Nurse Practitioners Act, allows a pharmacist to be sponsored or supervised by a physician and, acting under this supervision, to independently diagnose, prescribe and dispense drugs.

This program joins a long list of other groups whose members are attempting to practice medicine without proper training.

I believe there is no place for such a program in Mississippi and, if introduced, the concept of "Prescriptive Authority" will lead to multiple problems with deterioration of the relationship between physicians and professional pharmacists.

Hopefully, this new program will not be included as a part of a new Pharmacy Practice Act; however, if it is included I expect extreme opposition from medicine.

MYRON W. LOCKEY, M.D.
Associate Editor

At some time each of us will probably visit the country doctor's office at the Agriculture Museum. To date it is not funded. I realize that we are besieged daily for contributions to some cause or other, but we alone are responsible for this particular project. If each physician would contribute only \$20, our funding problem would be over. Please help. You'll be glad you did when you see it. — W.M.D.

Medico-Legal Brief

Chiropractors Limited To Manipulation

Chiropractors seeking to expand their fields of practice beyond the musculoskeletal manipulation to which they are generally restricted have been limited sharply by a decision of the Iowa Supreme Court. The case, part of a continuing effort to redefine chiropraxis, is a "manifestation of a protracted philosophical dispute between the Iowa department of health and the Iowa board of chiropractic examiners," the state supreme court said.

A strongly worded minority opinion decried the "discriminatory treatment of chiropractors," asserting that "no method of attempting to heal the sick, however occult, is prohibited."

The confrontation stemmed from an injunction issued in response to action by the state department of health, prohibiting a chiropractor from drawing a patient's blood for analysis, prescribing a diet, and performing acupuncture. The chiropractor had argued that the blood analysis — a diagnostic not a therapeutic procedure — and diet were necessary to support chiropractic treatments. He pointed out that he had been trained in acupuncture, a healing modality not ordinarily taught to orthopedists or other medical specialists. The chiropractor was thus filling a public need, he declared.

He and the Iowa board of chiropractic examiners, which joined his defense, argued along broader lines as well. It would be in the public interest to permit chiropractors to exceed the strict statutory limits, they said, because "with increased knowledge and experience, practitioners in any health field should be free to increase and expand techniques to health care."

The district court upheld the view of the health department and granted the injunction, however. That action has now been affirmed by the state su-

preme court, which chose to follow the old statutory limits barring chiropractors from drawing blood and ordering diets. The appellate court admitted that by denying chiropractors the right to practice acupuncture it was possible that a promising area of health care might be overlooked. On the other hand, the court noted, "some methods of health care may be deliberately left undeveloped because they are thought to be dangerous or worthless." It is not up to the courts, the judge concluded, to decide which medical modalities are promising and which are not. It would be "an abuse of power for us to second-guess the legislature on such questions."

Two dissenting judges pointed out, however, that if the statutory definition of a physician were fol-

lowed to the letter, it would prohibit the use of orthopedic devices, most forms of psychotherapy, radiology, and ultrasound. Moreover, they noted, the Iowa statute does not specify that physicians, any more than chiropractors, have the right to draw blood and prescribe diets. Iowa law defines physicians as "persons who prescribe, or prescribe and furnish medicine for human ailments or treat the same by surgery."

In arguing for a broader definition of chiropraxis, the minority declared that courts should not attempt to "make any particular mode of effecting a cure unlawful. but simply to protect the community from the evils of empiricism." The law should do no more than assure the public that practitioners of any medical system have attained a "reasonable proficiency," declared the two dissenters. *Citation: Iowa, 320 N.W.2d 599*

RECOLLECTIONS

Ten years ago, in the December 1972 issue, JOURNAL MSMA reported on hospital expansion in the Jackson area. The four-page article included descriptions of additions at St. Dominic (200-bed wing and five-story medical office building); University Medical Center campus (60-bed Mississippi Methodist Rehabilitation Center); Doctors Hospital (30-bed wing); Hinds General Hospital (30-bed addition); Mississippi Baptist Hospital (completely new, 600-bed facility); and VA Medical Center (proposed new research wing). The comprehensive article also described the newly-opened, 56-bed psychiatric facility, Riverside Hospital.

Dr. Charles R. Jenkins of Laurel, MSMA president, reported in his president's page article on a national conference on continuing medical education, and recommended that continuing education programs in Mississippi hospitals receive the highest priority in planning.

Scientific articles in that issue included: "Laparoscopy," by George R. Huggins, M.D. and Thano Exarchos, M.D., of Jackson; "Venomous Bites and Stings in Mississippi," by Hugh Keegan, Ph.D., of Jackson; and "Orbital Blow-out Fractures," by Edward L. Gieger, M.D., of Jackson.

"The whole of medicine is creating new problems as it solves others," said an article in JOURNAL MSMA twenty years ago. The item was a report of an address by MSMA president Dr. C. P. Crenshaw before the Mississippi Federation of Licensed Practical Nurses. In his address Dr. Crenshaw identified two primary problems facing medical practice at that time: more elaborate medical care requiring more and better trained people to render it, and the increasing number of people to care for in the latter years of life.

Another news article in the December 1962 issue of JOURNAL MSMA reported the election of Dr. Richard J. Field, Jr. of Centreville as president-elect of the Mississippi Chapter, American College of Surgeons, and the installation of Dr. William T. Thornton of Meridian as president.

Scientific articles in that issue included: "Use of Steroids in Rheumatoid Arthritis," by Glenn M. Clark, M.D., of Memphis; "Thoracic Traumas," by William G. Pace, M.D., of Columbus, OH; and "Virus Diseases — Crippling Effects and Recent Research," by Daniel Bergsma, M.D., of New York, NY.

MEDICAL ORGANIZATION

Verner S. Holmes Center Dedicated at UMC

The Verner S. Holmes Learning Resource Center at the University of Mississippi Medical Center in Jackson was dedicated in a ceremony on November 6.

Named for Dr. Verner Smith Holmes of McComb, who served on the Board of Trustees, Institutions of Higher Learning, from 1956-1980, the \$6 million, 77,913 square foot building houses the Rowland Medical Library and the UMC Division of Learning Resources.

Keynote speaker for the event was James P. Coleman, former governor and retired chief justice of the fifth circuit district of the United States Court of Appeals. Coleman appointed Dr. Holmes to his first term on the college board, when the medical center was just one year old and other board members thought the addition of a physician to the board



would interpret the needs of the center.

Coleman and other speakers credited Dr. Holmes with being the guiding force behind development of the young medical center and commended his many years of service on the college board and his dedication to excellence in higher education in Mississippi.

In 1982 Dr. Holmes received the Oliver Emmerich award for Distinguished Service presented by the McComb Chamber of Commerce. The McComb physician was twice honored by the chamber for his efforts to improve the community's medical and business climate. In 1978 Dr. Holmes received the Mississippi State Medical Association's Robins Award in recognition of his record of service to his community, state and nation.

Dr. Holmes was named the first chief of staff of the Southwest Mississippi General Hospital, a facility he was instrumental in establishing. He was chairman of the State Comprehensive Health Planning Committee for four years. He was also a member of the President's Committee on Employment of the Handicapped.

A Mason and Shriner, Dr. Holmes has served as a deacon in the J. J. White Memorial Presbyterian Church in McComb. He is also a member and former president of the McComb Rotary Club. He is a member and former director of the McComb Chamber of Commerce and past president of the Pike County Livestock Association. He is a past president of the South Central Mississippi Medical Society and of the Mississippi Eye, Ear, Nose and Throat Association.



Portrait of Dr. Verner S. Holmes by Marshall Bouldin, III, which hangs in the main lobby of the Verner S. Holmes Learning Resource Center.

Tulane Alumni Association Honors Dr. Cobb

Mississippi State Health Officer Dr. Alton B. Cobb received the Outstanding Alumnus Award for the School of Public Health and Tropical Medicine at Tulane University's Homecoming 1982.

Each year the Tulane Alumni Association selects one graduate from each school and college as an Outstanding Alumnus. Nominations come from the individual schools, their alumni groups, and individuals. The Association Awards Committee bases its selection on criteria which include professional excellence, prominence in the nominee's field of endeavor, and service to the University, the Alumni Association, and society in general.

Dr. Cobb earned his master's in public health degree at Tulane in 1960 and did a residency in public health with the agency he now



directs. He is a diplomate, American Board of Preventive Medicine in Public Health.

The State Health Officer has been serving in that position since July 1, 1973. Previously director of the Mississippi Medicaid Commission and of Comprehensive Health Planning in Mississippi, Dr. Cobb joined the State Board of Health as Sunflower County Health Officer in 1957 and served as director of the agency's chronic illness services from 1962 to 1968.

Responsible for establishing the public health district system for coordinating preventive health care services to Mississippi people from the state to local level, Dr. Cobb is a Madison County native. He is a University of Mississippi alumnus who earned his M.D. degree at Johns Hopkins School of Medicine and interned at Charity Hospital in New Orleans.

Dr. Cobb is visiting assistant professor, Tulane School of Public Health and Tropical Medicine, and a clinical professor of preventive medicine at the University of Mississippi School of Medicine.

Honored in 1981 as Mississippi's Public Administrator of the Year, Dr. Cobb is past president of the Association of State and Territorial Health Officials.

NOTICE

INTERNS, RESIDENTS, ANY PHYSICIAN LICENSED TO PRACTICE MEDICINE IN MISSISSIPPI

Positions for part-time medical consultants are now available at the Disability Determination Services of Mississippi. The pay and hours are good. Interns and residents wanting to interrupt their training programs for a year or more are welcome to apply. If interested, call 922-6811, ext. 2277 (Dr. John Barr) or ext. 2000 (Mr. John Cook).

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Guy T. Vise, Jr. Installed Chairman of SMA Council

Guy T. Vise, Jr., M.D. of Jackson was installed as chairman of the Council of the Southern Medical Association at its 76th Annual Scientific Assembly in Atlanta, October 30-November 2.

Dr. Vise is chief executive officer and medical director of the Mississippi Methodist Hospital and Rehabilitation Center and is a founder of the hospital. He is associate professor of surgery (rehabilitation) and assistant professor of orthopedic surgery at the University of Mississippi School of Medicine. Dr. Vise is on the staff of St. Dominic-Jackson Memorial, Doctors and University Hospitals in Jackson and is a charter member of the American Academy of Medical Directors.



Born in Meridian, Dr. Vise took his B.A. degree at Harvard and his M.D. degree from Tulane University. His postgraduate training was obtained at the Charity Hospital of Louisiana, the Scottish Rite Hospital for Crippled Children in Decatur, Georgia, and the Rancho Los Amigos Hospital in Downey, California. He was certified by the American Board of Orthopaedic Surgery in 1972.

Among professional societies to which Dr. Vise belongs are the American Academy of Orthopaedic Surgeons, the Association of Bone and Joint Surgeons, the International College of Surgeons, the American Congress of Rehabilitation Medicine, and the International Medical Society of Paraplegia.

He is a member of the Mississippi State Medical Association, and prior to his election as chairman of the SMA Council, Dr. Vise served as chairman of the SMA Committee on Publications and on the Committees on Dial Access, Finance, Membership, Personnel, and Telecourse. He has been a Councilor from Mississippi and on the Executive Committee of the SMA Council since 1978.

POSTGRADUATE CALENDAR

January 14-16, 1983

ADVANCED CARDIAC LIFE SUPPORT
University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center Department of Anesthesiology, the American Heart Association, Mississippi affiliate, the University of Mississippi School of Nursing and the Medical Center Continuing Health Professional Education.

Coordinator: Dr. George Lyon, instructor in anesthesiology.

The purpose of this course is to train and certify health professionals in ACLS as defined by the American Heart Association. As a prerequisite to the ACLS course, registrants must have successfully completed a Basic Life Support Provider Course. Fee: \$175. Credit: 16 credit hours in Category I of the AMA Physician's Recognition Award.

February 3-4, 1983

RENAL UPDATE 1983: REHABILITATION IN CHRONIC ILLNESS

Sheraton Regency, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Medicine, the School of Nursing and the UMC Division of Continuing Health Professional Education. Co-sponsors are Kidney Care, Inc.; the Kidney Foundation of Mississippi; the Mississippi Nephrologic Society and the Mississippi Urologic Society.

This year's symposium will focus on returning a patient with chronic illness to a productive life using kidney disease as a prototype. The seminar will also cover pulmonary, cardiac and gastrointestinal disorders. Fee: \$70. Credit: 9.1 contact hours AMA Category I, 9.1 contact hours AAFP.

DEATHS

READ, ALLEN MARTIN, Natchez. Born Picayune, MS, Oct. 22, 1925; M.D., Tulane University School of Medicine, New Orleans, 1951; interned Letterman Army Hospital, San Francisco, CA, one year; general practice residency, Lallie Kemp Hospital, Independence, LA, July 1953-June 1954; pathology residency, University Medical Center, Jackson, MS, 1963-67; died Oct. 14, 1982, age 56.

JOIN **MPAC** TODAY



PERSONALS

LEONARD D. BALL of Gulfport has been elected chief of the medical and dental staff at Memorial Hospital at Gulfport. Other officers are FRANK L. SCHMIDT, vice-chief and PHILLIP SACCOCIA, JR., secretary-treasurer.

CHARLES P. BASS of Columbia has been recertified as a diplomate of the American Board of Family Practice.

G. WILLIAM BATES of UMC was guest speaker at a meeting of the International Society of Reproductive Medicine in Scottsdale, Arizona.

RICHARD C. BORONOW of Jackson recently presented a paper at the postgraduate course of the American College of Surgeons in Chicago.

DAVID BYRNE of Gulfport has been elected chief of staff at Hancock General Hospital.

GUY D. CAMPBELL of Jackson was guest speaker at a recent meeting of the Pilot Club of Grenada.

THOMAS C. DAVIES has opened his office for the practice of family medicine at 521 West Drive in Okolona.

E. WARREN EVANS announces the opening of his office for the practice of internal medicine at 1117-23 Washington Street in Vicksburg.

RALPH M. FORTENBERRY has established his practice of family medicine at South Prentiss Medical Clinic in Prentiss.

ARMIN HAERER of UMC presented a paper at the Society of Clinical Neurologists meeting in Lake of the Ozarks, Missouri, and at the Central Society for Neurologic Research in Grafton, Illinois.

BECKETT HOWORTH, III of Jackson has been inducted into the Ole Miss Hall of Fame.

HERBERT LANGFORD of UMC participated in the program of the Symposium on Hypertension and Transmembranal Transport in Paris, France, in October.

GENE Z. MILIC announces the opening of his office for the practice of obstetrics and gynecology at 965 Avent Drive in Grenada.

JOHN MORRISON of UMC presented a paper at the Central Association of Obstetrics and Gynecology in San Antonio, Texas.

WALTER C. MOSES, JR. of Greenwood announces the association of KENNETH L. HINES for the practice of internal medicine at 405 River Road.

PYAR ALI NOORANI has established his practice of child neurology at 549 North Seventh Street in Greenville.

ANDREW PARENT of UMC presented a paper at Congress of Neurological Surgeons in Toronto, Ontario, Canada.

DAVID REEVES announces the opening of his office for the practice of pediatrics at 515 A LaRosa Road in Long Beach.

Radiological Group of Jackson announces the association of WILLIAM E. STUDDARD, JR., for the practice of radiology.

LAMAR WEEMS of UMC presented a program for the Delta Medical Center in Belzoni.

ROY WILSON of UMC participated in a workshop for new examiners of the American Board of Anesthesiology in Tarpon Springs, Florida.

GUY T. VISE, JR. of Jackson was installed as a fellow of the International College of Surgeons.

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FAMILY PRACTITIONERS. Excellent private practice opportunity, well equipped 30-bed hospital in operation less than two years. Office space available in renovated clinic, 100-bed nursing home, nice community, good schools and recreational facilities, located 30 miles east of Jackson. Call (601) 732-6252 or write A. B. Farris, Jr., Mayor, P. O. Drawer 338, Morton, MS 39117.

FAMILY PHYSICIAN wanted to locate in small town in central Mississippi. Excellent private practice opportunity. Large trade area. Established clinic with all equipment, including x-ray. Call (601) 253-2321. Mayor Grady Sims, Walnut Grove, MS 39189.

Situations Wanted

FAMILY PRACTICE resident seeks practice location in July 1983. Contact John D. Sites, M.D., 2002 Philip Dr., Muncie, IN 47302.

ANESTHESIOLOGIST seeks to relocate in state in solo, group or institutional practice. Contact M. T. Olivo, Jr., M.D., Box 794, Oxford, MS 38655.

BOARD ELIGIBLE PATHOLOGIST seeks practice opportunity. Graduate of University of Mississippi School of Medicine; residencies, UMC. Contact Marianna G. Pardue, M.D., 315 Cedarwood, Jackson, MS, 39212.

SURGEON seeks location with established group in small city. Currently service as chief surgical resident at Ochsner Foundation Hospital. Available July 1983. Contact Thomas C. Kelly, M.D., 1516 Jefferson Highway, New Orleans, LA 70121.

PATHOLOGIST-ONCOLOGIST seeks practice location. Frank P. Urso, M.D., P. O. Box 1149, Akron, OH 44301.

PATHOLOGIST seeks location upon completion of residency in June, 1983. Contact Robert M. White, M.D., Dept. of Pathology, Box 662, Medical College of Virginia, Richmond, VA 23298.

115th Annual Session

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Plan Now to Attend

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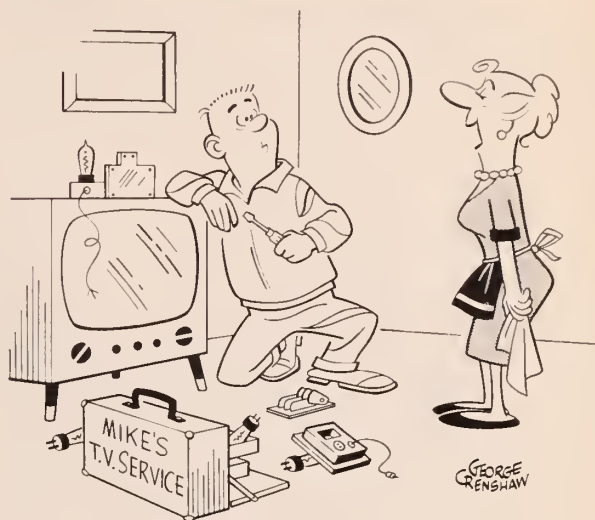
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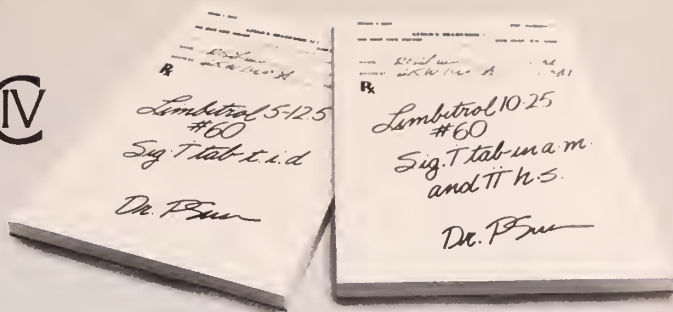
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References: 1. Claghorn J. *Psychosomatics* 11:438-441, Sept-Oct 1970. 2. Rickels K. Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, edited by Jorvik ME. New York, Appleton-Century-Crofts, 1977. p 316. 3. Baldessarini RJ, Torsy D. Tardive dyskinesia, in *Psychopharmacology: A Generation of Progress*, edited by Lipton MA, DiMascio A, Killam KF. New York, Raven Press, 1978, p 999.

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Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia

Gastrointestinal: Nausea, epigastric distress, vomit-

ing, anorexia, stomatitis, peculiar taste, diarrhea, black tongue

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment

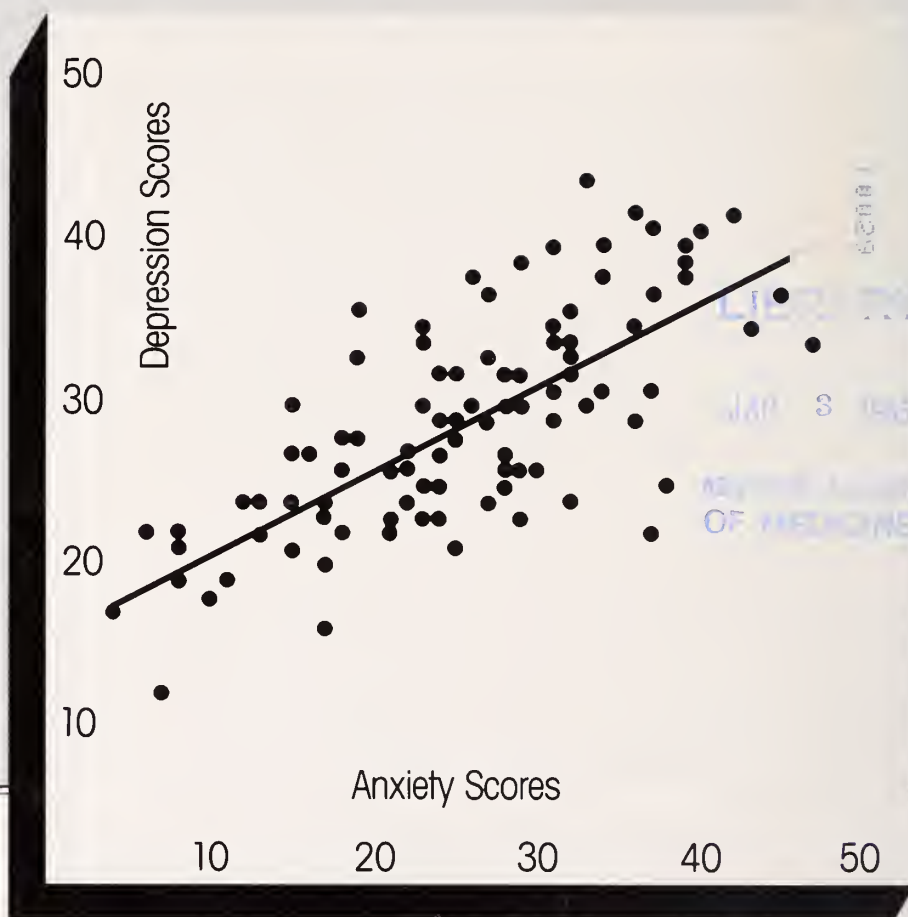
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E Dose® packages of 100, Prescription Paks of 50.



ROCHE PRODUCTS INC
Manati, Puerto Rico 00701

MORE DEPRESSION MEANS MORE ANXIETY...



The graph illustrates the close correlation between depression and anxiety derived through the MMPI and the Taylor Manifest Anxiety Scale in 100 nonpsychotic psychiatric patients. The Coefficient of Correlation is 0.7. As depression increased, so did the anxiety levels.

—Adapted from Claghorn J¹

A key reason why

MORE PHYSICIANS ARE CHOOSING LIMBITROL[®]

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)



1. Claghorn J: *Psychosomatics* 11:438-441, Sept-Oct 1970

Please see summary of product information on inside cover.





The New York Academy of Medicine

DUE IN 4 WEEKS UNLESS RENEWED
NOT RENEWABLE AFTER 8 WEEKS

[illegible]



